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ABSTRACT

This document contains witnesses' testimonies from the Congressional hearing held in New York to gain that state's perspective on health maintenance organizations (HMOs). The hearing was convened by Robert Blancato and prepared statements from Representatives Mario Biaggi and Thomas Manton are included. Chairman Biaggi's statement calls the hearing an opportunity to evaluate HMOs and their relationship to elderly participants and to learn about the requirements for becoming an HMO in New York, as well as existing regulatory safeguards at the federal and state levels. Three panels of witnesses representing the regulators, providers, and members of the New York health care community provide testimony. Panel One consists of Robert Biblo, president, Health Insurance Plan of Greater New York; David Perry, senior vice president, Hospital Association of New York State; and Robert Thompson, executive vice president, Greater New York Hospital Association. Panel Two includes Jacqueline Wilson, acting regional administrator, Health Care Finance Administration, Region II; Frank Seubold, associate director for Health Maintenance Organizations, Health Resources and Services Administration, U.S. Public Health Service; and David Horinka, director, Bureau of Alternative Delivery Systems, New York State Department of Health. Panel Three consists of William J. Kane, president, U.S. Health Care, Inc. and Warren D. Paley, president, Capital Area Health Plan, Inc. (NB)

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HEALTH MAINTENANCE ORGANIZATIONS: THE NEW YORK PERSPECTIVE

ED279965

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

FEBRUARY 24, 1986, NEW YORK, NY

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HEALTH MAINTENANCE ORGANIZATIONS: THE NEW YORK PERSPECTIVE

MONDAY, FEBRUARY 24, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
New York, NY.

The subcommittee met, pursuant to notice, at 10:45 a.m., at 26 Federal Plaza, room 305-C, New York, NY., Hon. Thomas Manton (acting chairman of the subcommittee) presiding.

Members present: Representative Manton.

Staff present: Robert Blancato, staff director; Sara Waterbury, staff assistant.

Mr. BLANCATO. My name is Bob Blancato. I am the staff director of the subcommittee, have been for the past 8 years and I have never had an experience like this happen in over 50 hearings we have had so far. However, out of respect for the time of our witnesses, and to make sure that we can stick to our schedule as reasonably close as possible, I am going to convene the hearing, request that the record show that this convening of the hearing is with the permission of the chairman, Mr. Biaggi, who, as I mentioned earlier, is incapacitated for this morning's hearing, but is successfully recuperating from a passed kidney stone which took place about 2 this morning.

I'll have to speak up until we can get the building management system to have the sound improve itself.

In any event, as was announced earlier, Chairman Biaggi is ill this morning. He successfully passed a kidney stone about 2 in the morning and is recuperating successfully at home, and Congressman Tom Manton, who is a member of the full committee and the subcommittee will be joining us momentarily and will serve as chairman of the hearing.

The purpose of getting started at this point is to convene the hearing and allow the first panel to begin their testimony and so that we can maintain our schedule as reasonably close as possible. I will, under unanimous consent, which should be easy to get in this situation, ask that the full statement of the opening statement of Chairman Biaggi be included in the record at this point, and I would like to have the first panel make their way to the witness table, and I will just make brief references to the opening statement.

Mr. MANTON. I want to apologize for being a little late. I understand our chairman, Congressman Biaggi, is ill today, and I got a

call in the District, where I was detained with some district work, to come down and substitute or pinch hit for him, and I apologize for any delay.

I am going to read Chairman Biaggi's opening statement, if I may:

OPENING STATEMENT OF CHAIRMAN MARIO BIAGGI

As Chairman of the Subcommittee on Human Services I am pleased to convene this morning's hearing entitled "Health Maintenance Organizations, the New York Experience."

I would like to welcome my distinguished colleague.

Referring to me; thank you, Mario.

In his first term in the House he has demonstrated consistent high quality of leadership on behalf of the elderly of this city and the nation.

We convene this hearing to launch a Subcommittee project of evaluating health maintenance organizations and their relationship to their elderly participants.

Health maintenance organizations are groups of health care facilities and personnel that provide a comprehensive range of services to members who enroll voluntarily and pay a fixed, prepaid fee.

As many people know, there has been an explosion of health maintenance organizations in the United States over the past five years. This development was substantially aided by the promulgation of new federal regulations permitting Medicare coverage for most HMO services.

New York has mirrored the nation with respect to HMO growth over the past five years. Yet, thanks to new regulations just issued in this state, we stand to leap far ahead of other states in terms of HMO expansion, especially in the "for-profit" sector. These new regulations provide special incentives for the "for profits" to enter the New York market. As a result there are now 30 new HMO applications pending state and federal approval in New York. A full 70 percent of these are from the "for-profit" sector. Approval of these applications would more than double the number of HMO's operating in New York, which is currently at 21.

Yet the approval of these applications by either the state or federal government must be accompanied by a responsibility to adequately monitor these HMO's.

Let us review some relevant local and national facts about health maintenance organizations:

Today there are a total of 393 HMO's operating in the United States. This constitutes a 67 percent increase since 1980. Of the total number of federally qualified HMO's in the nation, almost two-thirds are receiving Medicare funds. And consider this: In 1980, the Health Care Financing Administration paid out a little over 39 million dollars to its Medicare beneficiaries enrolled in HMO's. By 1985 that figure has multiplied 500 times to 2 billion dollars.

Another fact, the number of persons enrolled in HMO's now totals 18.9 million. A 100 percent increase since 1980. In New York State alone there are over 1.6 million enrollees. This includes 15,039 Medicare beneficiaries, of which 92 percent are elderly.

It is obvious, and reflected by the rapid increase in Medicare expenditures for HMO services, that more and more elderly are enrolling in HMO's. A central concern we have is to make sure monitoring mechanisms are in place at the state and federal level, to guarantee that services contracted for upon enrollment are fully provided. What we must be especially vigilant to avert is the so-called "creaming" of those who seek to participate in HMO's. This is when an HMO, in order to better balance its budget, screens out "high risk candidates," the poor and older patients who are more likely to utilize health care services, and then accepts only the healthier lower-risk clients.

Today in New York State more than 50 million dollars in Medicare funds are spent providing HMO services to elderly beneficiaries. This number, both in New York and nationally, will be growing as we continue to witness the rapid growth of our elderly population. The time is now to plan for this growth, but also to guarantee that the growth in HMO's does not become just a boon to business, while boondoggle to the taxpayers.

Our hearing today is designed as a learning process about the requirements for becoming an HMO in this state, as well as the existing regulatory safeguards, both state and federal, that exist. We have invited witnesses representing the regulators, providers, and members of the New York health care community.

In future hearings and related activities, we will focus more on actual consumers.

I might add that I conduct this hearing after having had the pleasure of reviewing a thriving health maintenance organization near Ft. Lauderdale, Florida just two months ago, and experience bears out the fact that HMO's can be beneficial to all concerned if everyone is protected. Those who operate HMO's can and do make substantial profits, and that is fine. Meanwhile, as was intended by the federal government, an HMO can lower costs to both the participant and the government, when compared to hospital based and institutional care. Both of these outcomes can be accommodated, but will take hard work, efficiency of operation, commitment to quality of care, and full accountability. We are most interested in the accountability issue, and hope to play a visible role. The main motivation behind this hearing and our subsequent work is to make sure that we act before problems occur, instead of simply being forced to react to them.

Once again, I would like to thank all the witnesses for their enthusiastic participation in this hearing, and especially thank U.S. Health Care for helping provide the T.V. and video equipment for our commercial presentations later on.

Ladies and Gentlemen, let me now introduce you to my colleague and good friend, Congressman Tom Manton of New York.

I am going to exercise the privilege of the Chair and not read my prepared statement in the interest of time, and ask that it be made part of the record, without objection, and we will go right to our first witness.

[The prepared statement of Representative Thomas J. Manton follows:]

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

Thank you Mr. Chairman. I would first like to thank you for inviting me to join you today and commend you for calling today's timely hearing. I am pleased to have the opportunity to learn first hand the impact of New York States' new regulations which, for the first time, allow the operation of for-profit health maintenance organizations in New York State.

The population of America is growing older. The oldest portion of our population, those over 85, growing the most rapidly. In addition, the proportion of older Americans is projected to rise dramatically during the next two decades. By the year 2010, more than one-fourth of the entire U.S. population is expected to be at least 55 years old.

At the same time the median age of Americans is rising, so is the portion of their income spent on health care. This is an alarming trend. Back in 1977, the elderly spent 12.3 percent of their income for health care. By 1990, however, our Nation's seniors will be spending 18.9 percent of their income on health care. The rising costs of health care seriously threaten the ability of our Nation's seniors to access quality health care.

However, another major problem is the impact on the Federal budget. With no change in current law, Federal expenditures on health are projected to increase from 2.7 percent of GNP in 1983 to more than six percent of GNP by 2030.

The Congress is currently grappling with the problem of providing cost-effective health care to a growing population of older Americans. One promising solution is Health Maintenance Organizations (HMO's). I understand that of the thirty HMO's which have submitted letters of intent or applications to operate in New York, five of these have applications for Medicare qualification pending with the Health Care Financing Administration. I am particularly interested to hear the ways in which HMO's can respond to the special needs of older Americans. I also want to learn of the Health Care Financing Administration's plans to monitor the expected proliferation of HMO's in New York.

Again, Mr. Chairman I would like to thank you for calling today's hearing. As always, you are one of Congress's leaders in calling attention to issues of importance to our Nation's seniors. I look forward to hearing from today's witnesses and plan to continue to monitor the issues we are discussing today.

Mr. MANTON. In order to accommodate our schedules, we would first request all witnesses to summarize their testimonies. Full statements will be included for the record.

Second, I would ask unanimous consent that for the duration of the hearing that the subcommittee staff director, Bob Blancato, be permitted to take testimony for the hearing.

Finally, I introduce, for the record, Sara Waterbury, who is serving on the subcommittee staff, to the left of Mr. Blancato.

Panel No. 1, and I will just read the names of the participants at the outset: Mr. Robert Biblo, president—the print is a little small here—Robert Biblo, president, Health Insurance Plan of Greater New York, also known as HIP; Mr. David Perry, senior vice president, Hospital Association of New York State; and Mr. Robert Thompson, executive vice president, Greater New York Hospital Association.

Mr. Biblo, I believe you are going to lead off.

PANEL ONE, CONSISTING OF ROBERT BIBLO, PRESIDENT, HEALTH INSURANCE PLAN OF GREATER NEW YORK; DAVID PERRY, SENIOR VICE PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE; ROBERT THOMPSON, EXECUTIVE VICE PRESIDENT, GREATER NEW YORK HOSPITAL ASSOCIATION

STATEMENT OF ROBERT BIBLO

Mr. BIBLO. Congressman Manton, members of the panel, staff, good morning. I will make every effort to try and summarize this statement. That may become a more difficult task than I am able to accomplish.

My name is Robert L. Biblo, and I am president and chief executive officer of HIP, the Health Insurance Plan of Greater New York.

I want to thank you for this opportunity to share on the record with you and with the Subcommittee on Human Services of the House Select Committee on Aging our perspective concerning New York's experience with health maintenance organizations.

HIP is the Nation's second largest health maintenance organization, or HMO, with approximately 900,000 members throughout the New York metropolitan area. HIP is also one of the oldest HMO's in the country, having started operations in 1947. The organization also served as one of the original prototypes for the Federal HMO Act of 1973. By way of background, HIP is a group practice HMO. This is to say that we offer comprehensive health care services to an enrolled population through an organized delivery system. The HIP delivery system consists of nine affiliated medical groups, which are in partnership with HIP. Medical groups are reimbursed on a capitation bases and practice full time on behalf of the plan's membership. The medical groups provide services to plan members through HIP's 60 health centers located throughout the New York metropolitan area. Physicians services are also provided in the hospital when hospitalization is required.

HIP offers enrollment to a broad cross section of the community and bases its premiums on community rating principles. This results in members paying essentially the same premiums for similar benefits, regardless of their health status or how often they use the plan. HIP's enrolled population covers all segments of the employer community, including small businesses, large corporations,

unions and governmental entities, as well as individuals who enroll on a non-group basis.

HIP also enrolls a large Medicare population. Currently almost 10 percent of HIP's membership of 900,000 enroll in HIP through the Medicare Program. Over the past 5 years HIP has experienced significant growth, as has the industry as a whole. Over the next few years it is predicted that we will continue to see overall growth in the number of HMO's and their enrollment. Given this growth picture, and the new Medicare At-Risk Program passed by Congress, it can be anticipated that Medicare membership in HMO's will begin to grow dramatically. Considering the significant role HMO's will be expected to play with regard to the provision of health care service to Medicare beneficiaries, the subcommittee's interest in HMO's and HMO performance is both timely and relevant. This would appear to be particularly true given the rapidly changing nature of the HMO industry, both nationally and most recently in New York State.

In New York State we will be witnessing the entrance of "For-Profit HMO's," many of whom are national in focus and for whom New York State will represent one of several locations in a national network or chain of HMO plans. This is in contrast to New York's experience with HMO's to date which has been limited to nonprofit organizations indiginous to the State and often limited in scope to a single community or metropolitan area. With the entrance of these new organizations, it can be expected that New York State will enter into a period of extensive HMO competition involving a variety of HMO approaches and structures affecting both the "For Profit" and "Not-For-Profit" models.

As New York State begins to reflect national HMO trends, it is appropriate to examine recent HMO development, what HMO's have traditionally stood for, and to identify those features of HMO's that benefit all enrollees, including Medicare beneficiaries, as well as some features newly introduced, which should be approached with an element of caution.

Although HMO's have been with us for many years, the HMO industry as we know it today really got its start in the early 1970's. At that time there was serious concern on the part of Government that health care costs were escalating beyond an acceptable rate, and that reform of the health care delivery system was needed. The Government's concerns were more than philosophical. The enactment of Medicare and Medicaid in the midsixties had placed Government in a position of a major payer and, accordingly, a party with strong interest in containing unacceptable increases in health care costs.

Given these concerns, considerable attention was given in the early 1970's health care delivery system and its financing, how it could be reformed, and the role Government might play in this effort. In the search for solutions the HMO concept was identified as one achievable way of addressing the major health care issues facing the country. This analysis led the Federal Government to formally endorse the HMO concept, citing for its position the following reasons—and I will run this briefly: One is the inflation rate; the desire to control cost by encouraging private sector initiatives, recognizing that the fee-for-service system had incentives

that were inherently inflationary, identifying HMO's as they existed at that time as both high-quality, cost-effective programs, and belief that HMO's on a large scale could market forces into play into the health care field; that HMO's would impact positively on the dominant fee-for-service system.

This strategy was embodied in the administration's document entitled "Toward a Comprehensive Health Policy for the 1970's, A White Paper." In essence, for the first time, Government, through this policy, challenged the existing fee-for-service system and also, for the first time, overtly intervened in the practice of medicine by supporting programs that reduced reliance on hospital costs and increased ambulatory services, encourage us to include cost in the medical decisionmaking process, and it led to a bipartisan effort which brought about Public Law 93-222, the Federal HMO Act of 1973. Passage of the act marked a watershed year for the development of the HMO industry; the act placed the Federal stamp of approval on HMO's providing funding for initial start-ups and affording access to the dual-choice mechanism in the law to employers.

In addition, the act initiated a significant and effective promotional effort and was designed to expand a small HMO movement. The Federal HMO effort has proved to be a landmark piece of legislation. In the 12 years since the act we have seen significant expansion in the HMO industry, an industry that is now growing at its fastest pace; sponsorship of HMO's, by a wide diversity of organizations, including many who originally opposed the HMO concept; an industry that has come of age in terms of private sector financial support; competition between organized systems of care, as well as the fee-for-service system; and a concept that is now well received by many employers, as well as an increasing segment of the public, and, more recently, by the Health Care Financing Administration which has adopted new approaches to provide care to Medicare beneficiaries.

The act accomplished what it set out to do. Moreover, the Federal act was implemented by and large without unnecessary or inappropriate regulatory interference. Most of the HMO's that have developed to date, federally qualified or not, have demonstrated it is possible to assume the responsibilities set forth in the act, in other words, to provide comprehensive quality care to a broad cross section of the community, and still be competitive and attractive to the consumers.

It is now argued that the Federal HMO Act has served its purpose and that the need for Federal regulation in the HMO industry has come to an end. Adherents of this position include some representatives of the present administration, certain employers, as well as a growing sector of the HMO itself. Others would fall short of calling for a complete repeal of the Federal act, but would nevertheless suggest that Federal oversight of HMO activity should be significantly diminished, particularly in those areas of the act where Federal requirements are perceived as barriers to conducting HMO operations in line with marketplace forces.

I am not surprised that pressure is building for a reexamination of the Federal role in the HMO industry, nor do I believe it inappropriate to consider whether a particular regulation or act has fulfilled its useful purpose. I would, however, suggest that we care-

fully consider the implications to the HMO field, its purchases and its members, concerning any changes in the HMO Act. Further, that there are public policy implications that must be considered before action is taken. I exercise this note of caution because I believe that some of the assumptions being made are still speculative in nature, and may prove to be erroneous over time. This is of particular concern to me where change is being suggested on the basis that the health care industry should function primarily in a free market or that market flexibility should be the overriding principle on which HMO performance is to be based.

If the HMO Act is dismantled, we are accepting the premise that the Federal level, that market forces alone will regulate the HMO industry and will do so in a way that is beneficial to consumers of health care. Many who would delete the Federal role argue that regulation will still exist but at the State level. Given the present status of State regulation of HMO's, this argument is faulty. The extent and nature of regulatory oversight of HMO's varies considerably from State to State. In an effort to promote uniformity, the National Association of Insurance Commissioners has published a model State statute for HMO regulation which is beginning to receive favorable hearing at the State level. However, it is far too soon to project that there will be uniform State regulation of HMO's, let alone to predict the contours of that regulation. Thus, if Federal oversight is removed, we must confront this issue on the basis that without Federal regulation there will not be consistent, structured, even applied regulatory oversight.

We are starting to get a taste of what unfettered competition can mean to the HMO industry. HMO's that have been committed to comprehensive benefits and community rating are now being forced to engage in regressive policies, including benefits slashing and selective experience rating in order to compete.

Do we really believe that encouraging HMO's in the name of competition to reduce coverage at the consumer's expense is a progressive action? Do we really want HMO's to begin shifting the burden for cost efficiency from the providers of care to the users of care? If not, then amending the act involves cautious consideration rather than severely eroding the act and its requirements in the name of market forces and free competition. Uncontrolled competition in health care has not worked to protect the consumer in the past and there is little evidence to date to lead us to believe otherwise for the future.

The individual purchaser of medical services is an atypical consumer. Americans have accepted the premise that when we are ill we need to see a physician. Further, it is the physician who in the exercise of his or her judgment is the best source for determining necessary treatment. Given these circumstances, the attempt to introduce cost consciousness into the medical decisionmaking process is better posited with the provider of care than with the consumer. Many of the competition proposals are directing their efforts as well as their incentives to the wrong party. If it is the physician who is and will continue to be the ultimate decisionmaker of medical care, then it follows that it is to the physician that cost-conscious behavior needs to be directed. Accordingly, proposals to reduce comprehensiveness of benefits and to introduce deductibles

and coinsurance, place an inappropriate burden on the consumer of health care, when in fact it is the provider who is responsible for making decisions that are ultimately cost effective or not cost effective.

In the traditional business environment, competition usually results in a better product. Is this the case in the health care field? For example, there is mounting opposition to community rating. Because the current Federal law does not permit experience rating, employers and HMO's who wish to do so are suggesting that the act be abolished or that community rating be eliminated as a requirement of Federal qualifications. The real question is not whether or not HMO's should be allowed to experience rate, rather, the real question is do employers and labor unions and members really want to see us get into experience rating on a broad scale.

I understand why employers who have employed populations that are younger and healthier than the norm would want to experience rate. Conversely, employers who have an aging population and a generally higher-risk population will bear the burden of extremely high premiums using experience rating. If the past is prolog to the future, the practice of skimming—in other words, seeking only healthy populations—will surface, which is exactly what the act encouraged HMO's not to do.

In considering the issue of experience rating and community rating, I would urge thinking long term. Experience rating is a two-edge sword. As an employee population ages and matures, today's advantage becomes tomorrow's high cost. Once experience rating is introduced on a massive scale, the socially useful purpose of community rating is eliminated. As a matter of policy, given a working population, is it appropriate to penalize employers and workers by increasing costs and reducing wage potential because of health status?

Another trend affecting HMO's nationally is the pressure for HMO's to introduce price flexibility through experience rating; others are seeking price flexibility through reduction of benefits. As with community rating, the issue of comprehensiveness is not specifically whether HMO's should be able to offer cheaper benefit packages, but what are the consequences of pressuring HMO's to do this? All payers of health care must consider methods for controlling the cost of health plans. Reducing benefits does reduce premiums, but it does not reduce health care costs, it merely shifts them. Furthermore, it shifts cost to the consumer of medical care, allowing providers to escape responsibility for cost efficiency. Another regressive aspect of cost shifting is that HMO's begin to look more like indemnity type fee-for-service benefits, rather than the reverse. The original intention of the act involved putting enough heat on the fee-for-service system so it would create its own cost-effective patterns in increased benefits in order to compete.

In this environment the pressure on HMO's to reduce benefits and erect financial barriers to care will be severe. And HMO's who wish to survive will begin engaging in the very practices we wish to modify when we embraced and supported the HMO concept. If the result of deregulation is cost shifting, benefit reduction, and large-scale experience rating in the HMO industry, then we need to consider the long-term implications.

I believe that New York State has taken a major step in addressing these considerations in the context of the recently promulgated State HMO regulations. The regulations reflect a strong commitment to the concepts on which the Federal HMO Act was based, and to which I have referred. For example, New York State HMO's will be required to offer their members benefit packages which encourage comprehensiveness of coverage. Further, the dangers of skimming have been addressed through provisions which require HMO's in New York State to actively seek out and enroll a diverse population, including employees of small businesses, Medicaid recipients, and beneficiaries of the Medicare Program. In addition, the regulations strongly encourage New York HMO's to retain the community rating principle contained in the Federal HMO Act and which have been reflective of the New York State HMO industry to date.

The regulations also reflect, in my opinion, a philosophical belief by New York State that the interest of HMO enrollees cannot be protected by market forces alone, but must include a balance between market forces and governmental oversight. To this end the regulations include provisions designed to protect HMO enrollees by assuring that HMO sponsors will be screened by the State of New York to determine if HMO's are well conceived, fiscally sound, and competently managed. In addition, the regulations require of all New York HMO's that they have formal programs for quality assurance and for responding to member complaints and grievances, provisions embodied in the Federal HMO Act and which have proved over time to have served both HMO and their members well.

Some proponents of competition would suggest that New York State's regulatory framework for HMO's is overly restrictive. At this point in time, however, considering the changing nature of the HMO field, the current New York State regulations demonstrate a prudent concern for the welfare of the State's residents who may elect to enroll in HMO's. This is particularly important for individual purchasers of care, such as Medicare beneficiaries, who even more than group purchasers look to the regulatory process for monitoring and oversight.

These New York State regulations mirror many of the provisions contained in the Federal HMO Act. These provisions, integral to the successful performance of the HMO industry to date, continue to have merit. I would urge that these provisions be retained, at least until the impact of the present and developing competitive era can be fully evaluated at the New York State and Federal levels.

Mr. Chairman, I apologize for reading so quickly. It was very difficult to condense the statement. Thank you.

Mr. MANTON. Thank you, Mr. Biblo.

Our next witness will be Mr. David Perry, senior vice president, Hospital Association of New York State.

STATEMENT OF DAVID PERRY

Mr. PERRY. Thank you, Congressman Manton.

My name is David Perry. I am with the Hospital Association of New York State, which represents 300 hospitals and long-term care facilities within the State.

The rapid expansion of HMO's and the recent State regs facilitating that extension, are obviously of significant importance to us. I, too, will attempt to summarize my statement as I go through it.

New York has experienced a moderate but steady growth in the number of HMO's in the percentage of the population enrolled. That moderate growth, however, is being replaced by a more than two-fold increase in the number of HMO's and aggressive marketing and expansion plans by the existing organizations. This is largely due to the new Health Department regulations which explicitly permit certification of "for-profit HMO's" for the first time in this State. In the short term these new HMO's must focus not only on enrolling individuals, but also on recruiting physicians who will agree to serve these HMO enrollees. These physicians are in large part fee-for-service physicians who have responded to the traditional incentives of that kind of program. The HMO's will be faced in converting that kind of a response in a health care environment to one of managed care, which in many cases, I don't believe, these physicians are prepared, at this juncture, to deal with. Many physicians in New York still view capitation plans as anathema to the traditional practice of medicine. And there is some concern that the new HMO's will attract a substantial number of enrollees, but may be unable to recruit a sufficient number of physicians at the outset to provide sufficient care to them.

One quick anecdote: In Rochester, some 10 years ago, the HMO movement was just beginning, and in response the local medical society decided to start up their own IPA, which they thought that they could control. Unfortunately, the physicians' marketing strategy was less than sophisticated. They placed the enrollment applications in the offices of the participating physicians, which assured them that most of their enrollees had some health problem. The resulting adverse selection ultimately financially destroyed the IPA, and in fact slowed down the further expansion of the HMO movement.

The fact that the HMO's in Rochester have rebounded from that early event to achieve their current, very substantial market penetration approaching 40 percent, is not necessarily a phenomenon that can be repeated elsewhere. Rochester is a community that is unique in many ways. It has a very paternalistic business community which has been involved in the health care delivery system for a number of years. The Industrial Management Council, which is a collection of the business leaders, was involved directly or indirectly in the development of the Rochester Area Hospitals Corp. and its Medicare waiver hospital reimbursement demonstration project, several other long-term care and health-related demonstration projects. And the recent almost overnight enrollment of 50,000 people in the Rochester Blue Cross plans, Blue Choice, was in no small part due to Eastman Kodak's direct encouragement to its own employees to enroll.

There is no comparable community elsewhere in the State. Certainly, New York City, which is the primary target of many of the new HMO's is nothing like Rochester. Its business community is as

diverse as the people who live here. Marketing through New York City based employers will reacquire HMO's to have a physician network that extends into New Jersey and Connecticut, as well as the very large New York metropolitan area. While not insurmountable, this market will be a very substantial challenge. Compounding the challenge, obviously, is the number of HMO applicants themselves. They will be competing with one another, and this could result in price competition with inordinately low premiums established and target marketing to enroll only the best risks. This type of scenario could happen despite the limits imposed in the New York State regulations, and could have financial implications not only for the HMO's, but for traditional, experience rated health insurance plans as well.

From a hospital vantage point, a very serious short-term issue is the rate of payment to hospitals by HMO's for in-patient service rendered to enrollees. Currently, it is difficult but possible for HMO's to negotiate payment rates which are below the established Blue Cross payment rate. This is to allow the HMO's to benefit from preadmission workup on their enrollees, prior to hospitalization. And the advantage is also extended because of New York's historic endorsement of expanded HMO penetration and the not-for-profit status of the existing organizations. As this marketplace becomes more competitive and an increasing number of HMO's are "for profit," the advantage of paying a low cost rate must be reexamined.

Since New York does not have significant experience with these "for-profit" HMO's, if we move the reimbursement system for hospital services to a per case price from a per diem rate approach, which has been our tradition, we should not automatically extend the protection of Blue Cross rate payment as a ceiling to the new "for profit" HMO's. We may find that these new HMO's admit a more intensely ill patient than the general population because of the emphasis on minimizing hospitalization until absolutely necessary.

Despite some of the short-term marketing obstacles, particularly in the city, it is fully expected that there will be substantial market penetration by the HMO's. The longer term implications of a significant market penetration include at least four major issues from our vantage point.

First, the provision of services to the medically indigent.

Second, the preservation of a base for medical education and research.

Third, accommodation of significant changes in services mix and capacity within the hospital system.

Fourth, the assurance of quality and protection against underutilization of health services.

New York's hospital system has borne a tremendous burden of uncompensated care for the medically indigent, and although much of that has been in the in-patient setting, a substantial amount also comes from out-patient services. The problem of indigent care is significant enough in this State that the legislature has incorporated a special compensation mechanism in the current hospital payment system. The system requires non-Medicare payers of hospital services to add a certain percentage to their payment rate to fund

bad debt and charity care. And since Medicare can't accommodate that kind of system, hospitals contribute 4½ percent of their in-patient revenue to this uncompensated care system. This add on and hospital contribution is placed into a statewide and regional pools for subsequent distribution to hospitals, based on their actual bad-debt and charity care experience. Health maintenance organizations, at this point, like other non-Medicare payers, must pay this rate add on.

However, this concept, this pool concept, is only a temporary solution. The current statute expires at the end of 1987. In the meantime a more equitable and permanent solution to funding uncompensated care must be developed. The Hospital Association of New York State and the legislature's own council on health care financing have each established committees to work on a new system of financing uncompensated care, and certainly health maintenance organizations will be a factor in that. The traditional method of financing uncompensated care certainly is not acceptable, where hospitals have shifted the costs of rendering services to medically indigent patients to paying patients. Those paying patients and their corporate sponsors will not tolerate that further.

Further, if significant declines in in-patient hospital utilization occurs, as is projected with expansion of HMO's, there will be a much smaller base of paying patients on to whom that burden can be shifted.

Related to the problem of uncompensated care is the care of the Medicaid population. While the State law has paved the way for enrollment of Medicaid recipients and the new regulations require applicants to demonstrate a willingness to serve Medicaid, experience to date has not been that rewarding. Only a little more than 40,000 Medicaid recipients are currently enrolled in HMO's in New York. One-half of that amount are in the Monroe Medicap special demonstration project in Rochester, where a social service district contract with the Rochester Health Network facilitates Medicaid participation in that capitation program. It mandates Medicaid recipient participation.

The difficulty in enrolling Medicaid recipients in HMO stems from the lack of understanding of the system and the lack of incentives. Medicaid recipients enjoy complete freedom of choice. They choose the provider and they choose the site of service and have no personal financial cost. HMO enrollment carries with it a loss of that complete freedom of choice and their own personal independent management of their access to the health care system. If we are to facilitate much greater expansion of Medicaid participation, we will have to create some new incentives and, obviously, a greater understanding on the part of the Medicaid population.

In addition to the problems associated with providing the Medicaid population, we must provide the Medicaid population with an understanding of emergency coverage, out-of-area limitations, and loss of freedom of choice, and we have to have a greater commitment to seriously enroll the low-income population. Perhaps an open enrollment requirement for the Medicaid population would be appropriate.

The effects of reduction in hospital utilization that would come from expanded HMO enrollment will not only be felt in the area of

uncompensated care, medical education and clinical research have their roots in the hospital setting, and financing for graduate education, in large part, flows through the in-patient hospital payment mechanism. The reduced volume of in-patients that is projected will obviously carry with it a corresponding reduction in financing for graduate education. We must look at the financing mechanisms and come up with some alternate means to do it.

In addition to the financing issues, we must develop mechanisms to integrate graduate education programs in the HMO setting. As I mentioned earlier, the fee-for-service tradition of medicine is not compatible with capitation programs and physicians in graduate training must be trained in the managed-care environment. So new mechanisms must be established to integrate graduate education into the HMO setting itself. There must be identified the organizational programmatic and financial issues to accomplish that, and that should be done soon.

A substantial penetration by HMO's will have an effect on the distribution and capacity of hospital services as well. There is evidence that HMO's will contract with hospitals for specific services. Where, for example, a patient might be referred to hospital A for normal deliveries, other patients to hospital B for burns care, to hospital C for pediatrics, and so forth. Decisions by HMO's to make these selective arrangements are based on considerations of price, very often, and for the most sophisticated services on assessments of quality.

Studies have shown that referring to patients to hospitals with high volume of the high-risk, more sophisticated services will have a positive effect on quality. But in addition to those quality considerations, financial consequences of such changes in service mix and capacity must also be considered. The hospital payment mechanisms that currently exist are based on average costs of caring for patients, whether they be average costs per diagnostic related group, or average costs per day, as under our current New York reimbursement system. Because the selective contracting arrangement will have an effect on severity of illness and the intensity of service rendered in different hospitals, the Medicare payment system, the current PPS system, as well as the reimbursement methodology for New York, must be modified to incorporate differential payments based on severity and intensity of service within various diagnostic categories.

The issue of quality assurance is high priority for all of us. And although studies indicate that the quality of health care provided by HMO's is no better nor no worse than that provided in the traditional fee-for-service system, the rapid growth and the number of subscribers and participating physicians mandates careful analysis in monitoring of quality and utilization. Hospitals will have to reorient some of their traditional utilization and quality monitoring mechanisms. They will have to examine admissions to determine if the severity of the case is in any way related to under provision of service prior to hospital admission, or whether the admission itself has been unnecessarily and inappropriately delayed. As with cases paid for by Medicare PPS, they will also have to monitor for premature discharges of patients whose conditions are not medically stable. This kind of system where hospitals and HMO's voluntarily

and jointly undertake quality monitoring systems can identify weaknesses and can develop corrective actions where they are necessary.

There have been suggestions at the Federal level that the Medicare peer review organization should be required to extend their review to HMO enrollees. In the absence of explicit evidence of major and systemic quality problems, such governmentally imposed external review mechanisms are viewed as inappropriate.

In summary, the changes we anticipate arising from the substantial expansion of HMO's in New York are significant. They will add to the challenge of devising a permanent solution to financing uncompensated care; graduate education programs will have to be reoriented and integrated into the HMO environment; changes in service mix and capacity will have to be managed to assure programmatic and financial viability of many hospitals. Certainly incentives must be developed to encourage greater or even mandated enrollment of Medicaid recipients, and hospital reimbursement mechanisms will have to be modified to adequately reflect differences in intensity and severity of services rendered in hospitals.

Finally, hospitals and HMO's must design and implement cooperatively and collectively mechanisms to assure the sustained provision of high quality health care services.

Thank you.

Mr. MANTON. Thank you, Mr. Perry.

Our next witness will be Mr. Robert Thompson, executive vice president of Greater New York Hospital Association.

STATEMENT OF ROBERT THOMPSON

Mr. THOMPSON. Thank you, Congressman Manton.

I am happy to be here. What I will try to do is summarize quickly a couple of points particular to the New York City concerns about the development of HMO's.

First of all, let me say that the hospital industry in New York City supports the development of HMO's and their introduction into the medical care system. We believe that they can improve access to care; that they can represent a greater value for the dollar of purchase; and that they can give care that is equal to, if not superior in some cases, to the kind of care delivered in our system right now.

In fact the support of the hospital industry for the development of HMO's in the city is witnessed by a number of the hospitals who are members of an association participating in equity arrangement developments with one of the providers of care entering into New York. We believe that this diversification or pluralism of the health care delivery system has the potential to serve all of the users of the health care system better in the long run.

We have big concerns about some of the projected penetration in New York City. As you look around the country in other urban centers, you see the penetration has been driven mostly by large industries within metropolitan areas, driving employees into the HMO enrollment. That is not going to be the case, we believe, in New York City, because New York City is made up of a diversification of businesses, all employing smaller numbers of employees.

And, therefore, we don't believe that there will be the large push into HMO's that we have seen in other parts of the country. We do believe though that there will be penetration of some significance. We just think we had better be cautious about how significant we look for those numbers to be. And within the context of that, we have some concerns that we would like to share with you.

First of all, these concerns are driven by some of the statistics in New York, and I will just briefly cover them:

No. 1, the indigent care that Mr. Perry spoke about, as you well know, Congressman, lives in New York City beyond any other place in New York State. We are the most concerned about the care for the medically indigent in this State.

Second, 24 percent of our population is below the poverty level in this city, which is close to double the rest of the country. When you look at the statistics about our elderly population, we have 14 percent of people over 65, but they consume 40 percent of the health care resources. And we have a population of over 85 of age, which represents slightly over 1 percent of the population, but consumes almost 7 percent of the health care resources.

We have a diversified elderly population in New York, we are looking for something on the order of a 65-percent increase between 1980 and 1990 in this population. And of particular concern to us is the segment of that population that lives alone. We experienced a 13½ increase between 1970 and 1980 of people living alone over age 65. Presently 32 percent of all people over 65 live alone.

This is not a homogeneous population. It is a poor population; an older population; a population living alone. And our concerns, therefore, are driven by the nature of that population, and I would raise three for your consideration:

First of all, we think that there is a community responsibility here that has to be carried out by all providers of health care. Very simply put, our system in New York City and New York State is kept in balance because access is guaranteed on one hand because payment is supported on the other hand. The paper, Mr. Perry's comments and even Mr. Biblo's comments, make more explicit that concept. But simply there is a tradeoff between access and payment. If, in fact, you allow some of the players in the game to operate outside of that tradeoff, you begin to take away some of the patients that are built into that system and help preserve the access. If you do that the community responsibility is weakened and the access, which we have in our system right now, could be seriously jeopardized.

One of the key components of what might jeopardize that access is what we call negotiated arrangements or being able to set a price below the going rate. That going rate is established in order to maintain the balance of access and payment. Again, we are particularly concerned that if you are allowed to draw off patients into the HMO setting, you will leave the hospitals caring for—both on an in-patient and an out-patient basis—the more frail elderly, the more uninsured and poor individuals in New York City, and you will exacerbate the problems of coverage for the indigent and access to health care.

Finally, we are concerned about the Medicare population. As the statistics that I rattled off to you demonstrate, we are the diversi-

fied population. We have a lot of people who are over 65; a lot of people over 75 and 80; a lot of them living alone. We're concerned that the Medicare capitation rates for HMO's must be set, taking the diversification of this population into consideration. If you set the rates simply based upon an assumption of an over 65 type of population that is at a medium-risk level, and don't take into consideration the over 75 and over 85 population which is poor, living alone, and more at risk for health care, then you won't be setting rates that are adequate to the population, and access to the Medicare population, to this truly beneficial organization of health care might be seriously restricted.

Those are our concerns, driven by some of our observations about the population in New York City. I welcome the opportunity to present them to you.

Mr. MANTON. Thank you, Mr. Thompson.

[The prepared statement of Mr. Thompson follows:]

TESTIMONY OF ROBERT H. THOMPSON, EXECUTIVE VICE PRESIDENT, GREATER NEW YORK HOSPITAL ASSOCIATION, HEALTH MAINTENANCE ORGANIZATIONS IN NEW YORK STATE

Good morning Congressmen Biaggi and Manton, I am Robert H. Thompson, Executive Vice President of the Greater New York Hospital Association which represents 68 voluntary hospitals and health care institutions in New York City. I am here today to discuss Health Maintenance Organizations in New York and the major concerns of the Association resulting from the new regulations.

The entrance of Health Maintenance Organizations (HMOs) into New York City is certain to have profound impact on the market place and the delivery of services. HMOs, as a healthcare delivery system, provide many advantages not only to enrollees but for the system as a whole. As a coordinated and comprehensive delivery system, HMOs can provide enrollees with: improved access to care; greater value; and care that is equal or superior to that provided in more traditional settings.

In addition, the presence of one or more HMOs has been shown to increase competition which has led to improved cost containment, reductions in hospitals' utilization rates and expansion of benefit packages. Several New York City hospitals have initiated equity arrangements with HMOs because of their commitment to the healthcare delivery system. For example, Montefiore Medical Center, in your Congressional district, has joined several other hospitals in entering into an equity arrangement with a major national HMO chain. Examples like this, which involve pluralism in healthcare delivery systems, benefit everyone but particularly consumers who ultimately have greater choices.

Despite our general support for HMO development, we would be remiss in not pointing out that HMO penetration in New York City may not meet the rapid expectations that some have suggested. Clearly, the New York market will not follow the Minneapolis market experience. New York, unlike other large cities is composed of a large number of employers that individually employ a relatively small number of employees. The Greater New York Hospital Association is cautious in its estimates of the degree of penetration HMOs will achieve.

The Association has prepared a document entitled "Health Maintenance Organizations in New York State: Definitions and Profiles" which profiles twenty HMOs planning to enter the New York State market. This document has been provided for your information.

Holding our expectations aside, there are a number of unique circumstances in New York City which need to be considered. New York City is unique in that its health care delivery system serves a broad range of needs.

Over 24% of the population is below the national poverty level - close to double that for the rest of the country.

The elderly, a growing portion of the population, utilizes a disproportionate share of health resources.

In 1984, the 65 and over age group, which represented approximately 14.5% of the total New York City population accounted for 40% of all hospital patient days.

The 85 and over age group which represented 1.1% of the population accounted for 6.9% of all hospital patient days.

Population projections for 1990 estimate that the population 65 and over will only continue to increase and will represent an even greater proportion of the total population. It is projected that there will be a 65% increase from 1980-1990.

There is an increasingly larger percentage of elderly people living alone. From 1970 to 1980 there was an increase of 13.5%. Presently 32% of the 65 and over in New York City live alone.

The HMO industry must acknowledge and account for both the indigent population and the elderly population in New York City. Although the new HMO regulations require HMOs to show a willingness to enroll both Medicaid and Medicare recipients, they contain no language which indicates how this is to be assessed and monitored. HMOs in New York City will serve only an insured population and their initial targets for enrollment will certainly be the employed, not Medicare and Medicaid recipients. At present, there is no mechanism for coverage of the medically indigent in HMO systems.

COMMUNITY RESPONSIBILITY

The HMO industry has a responsibility to the community and must therefore seek to enroll a cross section of the population. If HMOs are permitted to select only a single segment of the market and not share in the community responsibility to care for the entire population, hospitals will be left with the high risk, uninsured patients and will have less revenue with which to absorb nonpayment by these high risk groups. This will only exacerbate the problems of access for the growing medically indigent population. Their access to both primary care and acute care will be reduced as providers' ability to provide care, with only limited remuneration, is increasingly limited.

NEGOTIATED ARRANGEMENTS

The issue of negotiated arrangements is particularly problematic. While straight negotiated rates for HMOs can not be established below the Blue Cross twelve percent discount level, special arrangements such as capitation can be developed. These arrangements can establish hospital reimbursement rates even lower than the Blue Cross rate and leave hospital providers at risk. New York State has a highly regulated system of hospital reimbursement through the New York Prospective Reimbursement Methodology. Regulation helps to ensure access, and through a tradeoff, assures some payment through the bad debt and charity care pools. Allowing one element in the system, HMOs, to "play outside the rules" will upset the balance of access and payment. Either the system must eliminate the rules and regulations or it must require all players to play by the same set of rules.

ACCESS FOR THE MEDICARE POPULATION

The third major concern of the Greater New York Hospital Association is to ensure adequate access to HMOs for the Medicare population. Although the revised HMO regulations require HMOs to show a willingness to enroll Medicare recipients, they do not provide a mechanism to assure equal access regardless of health status. Therefore, there is a potential for HMOs to enroll only the younger and healthier Medicare population. In New York City, those 65 and over is a population with a broad range of needs from the healthy couple living together with adequate financial resources, to the very sick with multiple health problems living alone, and poor and without adequate financial resources.

We are concerned that Medicare capitation rates will be set at levels which encourage HMOs to enroll only people 65 and over with low risks. This would result in excluding the older, the sicker, the poorer, and the high risk population from participation in HMOs. These needy elderly will be left outside the system.

Unless Medicare payment rates adequately take into account, the non-homogenous nature of the New York City 65 and over population, there will be severe limitations to the access afforded this group.

In conclusion let me summarize the points raised in this testimony.

The HMO industry has a responsibility to the community and must be encouraged to enroll a cross section of the population.

Permitting HMOs to negotiate special arrangements for hospital payment can offset the balance created in this regulated environment.

The lack of a mechanism to ensure equal access to HMO participation and adequate payment rates for Medicare enrollees may result in limiting access for higher risk people 65 and over.

Mr. MANTON. That concludes the testimony of the first panel.

We have a couple of questions before we go to panel No. 2.

This question is for all of the panel participants, and because we are part of the Select Committee on Aging, our special concern is the HMO experience as it relates to the elderly. The question would be: How would you evaluate HMO performances with respect to the elderly? Please respond in any order.

Mr. BIBLO. To date, the over 65 population in traditional group practice or IPA-HMO's throughout the country, they are underrepresented. That is, it is rare that a population in an HMO mirrors that in terms of size and numbers, to that of the community at large. I would say HIP comes closest to it with almost 10 percent of our population over 65.

In addition to that, I would like to comment just briefly on a related point. The issue of the risk of the population in an HMO, over 65, relates to how long they have been in. That is, you tend to always get a younger population enter in the picture. As the years go by and the population ages, you tend to have a high-risk population. A high-risk population stays, it never leaves. Only the low-risk population leaves. So while it is a concern, HIP's population, over 65, will mirror the population of the New York community at large. A newer program, that probably will not happen for a number of years, until the population ages.

Mr. MANTON. Mr. Perry?

Mr. PERRY. I would only add to that I think our experience with enrolling the Medicare population in New York is too limited to really project its implications now into the future. The rapid expansion of the number of HMO's, the increased availability and access to the Medicare population and the increasing number of these HMO's actively marketing to them, will achieve, I believe, a substantial market penetration among that group. It is probably the effects of the Medicare enrollment ultimately that will have the greatest impact on hospital utilization.

If statistics elsewhere hold true, that the over 65 Medicare population uses hospital services at 4,000 days per 1,000 beneficiaries, and with substantial enrollment, that can be reduced to the range of 2,000, plus or minus a bit, the effect on the numbers of hospital services that will be required will be diminished very significantly. That ties in the concerns of the capacity of the system as it currently exists, to continue to deal with graduate education, care of the medically indigent, and support of a pluralistic health-care system.

Mr. THOMPSON. Just quickly, whether it's Mr. Biblo's point about who remains enrolled in the HMO that are already enrolled, or a significant population outside of the HMO enrollment right now, the issue is the same. If we don't recognize that the individuals, as they get older, are more at risk and consume more health care services and set the rates for payment for the individuals appropriately, an organization that has individuals already enrolled will not be able to accommodate the needs of those individuals within payment rates and there will be no incentive for new HMO programs to enroll Medicare beneficiaries and that will limit its usefulness to the population of New York City and, I would assume, nationally.

Mr. MANTON. I have a question for all the panelists: Now that New York is embarking in the Federal DRG system, what effect will that have on HMO's, if any?

Mr. THOMPSON. We will go the other way this time.

I believe that the combination of perspective pricing and peer review activity in the Medicare Program points in the direction of a managed care approach for Medicare beneficiaries. I believe that, therefore, the ability of the HMO approach to accommodate the Medicare population into providing the appropriate management care, I think is consistent and important. And that is why our concern—that is, as we proceed to establish this mode of care and organization of care for Medicare recipients, that it is done not solely with eye on price tag, but with eye on organization and delivery of range of services appropriate to the population.

Mr. MANTON. Mr. Perry?

Mr. PERRY. The incentives of the PPS system, the Medicare DRG payment mechanism, are not totally dissimilar from the incentives in a managed care environment. In fact, in-patient utilization is expected to shrink rather dramatically. I think that, and the competitive nature of retaining a substantial market share at the hospitals, is having them organizationally look much more aggressively at HMO's as potential joint-venture sponsors. That is one of the reasons we are seeing hospitals here in the city joint-venture with HMO providers in organizations.

I think it is also having an effect on physicians in some areas looking more positively toward the managed care programs as a means to sustain their own practices.

I will say that it is interesting, with joint-venture sponsorship by hospitals, they will look at the referral mechanisms of patients. If you have a major tertiary care center that is a joint-venture sponsor, in many cases they are going to be forced from their profit-making motive, or equity-ownership motive, to refer patients elsewhere, instead of their own high-priced hospital, which will have some interesting, longer term consequences.

Mr. MANTON. Mr. Biblo?

Mr. BIBLO. I do have a specific comment here that may gear in the opposite direction of my two colleagues. That is simply that for HMO development, I would caution the implementation of DRG's in terms of the HMO's incentives. That is DRG's create a system that really relate to the norm for length of stay. And HMO's that really are able to reduce length of stay—including good, quality assurance mechanisms to make sure the patients are not released before appropriate or they are not released at home without someone to take care of them—the fact is the incentives, the financial incentives, to reduce hospitalization are somewhat limited to an HMO when, in fact, they are going to be charged the going rate, regardless of length of stay that they were able to achieve.

So that from that perspective, HMO's particularly that are not married to hospitals, that don't have a joint venture with a hospital, have expressed some concern in this area. The New Jersey experience for HMO's has not been a perfect one in the sense that the incentives for reducing length of stay has been somewhat limited as a result of the DRG system.

Mr. MANTON. We are going to have more questions, but in the interest in staying on our schedule target, we will submit them to the witnesses for written response.

I have one last question of Mr. Biblo, and then we will conclude with this panel.

This was referred to in the testimony. How widespread is the issue of "creaming" or "skimming," as it relates to the elderly?

Mr. BIBLO. At this stage of the game, within the HMO system, I see no evidence whatsoever of the fact that the existing HMO's that provide care to an over-65 population are doing that. My caution is that the field is enlarging; that the numbers of players are increasing dramatically, and where they are coming from are out of thin air, individuals that I nowhere thought would be interested in health care.

In addition to that, some of the players entering in the game were those who were experts in the insurance industry in the 1950's and 1960's, who learned how to skim, who in fact forced Blue Cross to get away from a basic community rating concept into experience rating, because they learned how to get employer groups that were low-risk populations. And until all these players have been involved in systems, I feel regulation is of great importance, because the incentives right now are very much in the direction of seeing skimming revised.

In all honesty, to date I have not seen any of the players that I am familiar with playing that game with the over-65 population. On the other hand, the near 95 percent program, the program being implemented by HCFA has some of those very same incentives that created skimming as a popular mode of doing business in the 1950's and 1960's.

Mr. MANTON. Thank you, Mr. Biblo.

That concludes the panel. Thank you, gentlemen, for bearing with us and giving excellent testimony.

Panel No. 2 will consist of Ms. Jacqueline Wilson, Acting Regional Administrator, Health Care Finance Administration; Dr. Frank Seubold, Associate Director for Health Maintenance Organizations, Health Resources and Services Administration, U.S. Public Health Service; and Mr. David Horinka, Director, Bureau of Alternative Delivery Systems, New York State Department of Health.

Welcome panel No. 2.

PANEL TWO, CONSISTING OF JACQUELINE WILSON, ACTING REGIONAL ADMINISTRATOR, HEALTH CARE FINANCE ADMINISTRATION; DR. FRANK SEUBOLD, ASSOCIATE DIRECTOR FOR HEALTH MAINTENANCE ORGANIZATIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. PUBLIC HEALTH SERVICE; DAVID HORINKA, DIRECTOR, BUREAU OF ALTERNATIVE DELIVERY SYSTEMS, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. MANTON. Ms. Wilson, do you want to start off?

STATEMENT OF JACQUELINE WILSON

Ms. WILSON. Good morning, I will try. Please excuse my little laryngitis, but if you live in New York you know what happens here.

To try and help speed up things I will submit my written statement and try to give you a quick summary.

I am the Acting Regional Administrator of the Health Care Financing Administration for Region II. Region II encompasses New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands. I am pleased to be here today to discuss with you the administration of the HMO and CMP program under Medicare.

Currently in New York State we have 5 risk contracts, with 12,689 enrollees and 2 court contracts with 1,559 enrollees. There are also three applications for risk contracts pending in the State.

You have asked for our comments on the entries of the "for-profit" HMO's in the New York State market. Let me first state that the statute and Federal regulations clearly define the organizations that are eligible to enter into risk contracts, and the qualifying conditions they have to meet before a contract can be signed.

For HMO's any organization that meets State law and is federally qualified under title 13 of the Public Health Service Act, as Dr. Seubold will describe, is eligible to apply. The competitive medical plans, that is the CMP's, an organization must be determined by the Public Health Service to meet the statutory definition, which includes the requirement that it be organized under State law. For all practical purposes to Medicare, both HMO's and CMP's are the same—entities that provide a full range of health care on a prepaid capitation basis.

There are five areas covered in qualifying conditions for an HCFA contract. They include, first, Administration and Management: The organization must demonstrate that it has sufficient administrative capability to carry out the requirements of the contract, and that it has no agents, management staff, or persons with ownership interests who have been convicted of criminal offense related to their involvement in Medicare, Medicaid, or other Social Security Act programs.

Second, Operating Experience and Enrollment: The organization must demonstrate that it has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate. That is at least 5,000 commercial enrollees.

Third, Range of Services: The organization must demonstrate that it is capable of delivering to Medicare enrollees the range of required services, that is, for part A and part B services under Medicare.

Fourth, Furnishing Services: The organization must furnish the required services to its Medicare enrollees through Medicare certified providers and suppliers. It must also ensure that all services for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.

Fifth, Quality Assurance Program: The organization must have an acceptable quality assurance program.

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If an organization meets these requirements, HCFA will sign a contract. There is no basis for denying a contract if the applying organization is "for-profit"; nor do we think that such a barrier to competition is desirable. Each plan that meets the PHF qualifying conditions, none of which is financial stability, should be allowed to enter the Medicare market. Beneficiary choice and the rigors of the market should determine which organizations succeed.

Once a contract is signed, HCFA still has a role of ensuring that the organization continues to meet the qualifying conditions of the contract. This oversight function is the responsibility in New York of my office. HCFA is developing a protocol to assure that future monitoring is done in a consistent manner across regions. It covers a wide range of areas from marketing to grievances and appeals. For each area, there will be elements to examine based on concrete factors.

For example, in the area of beneficiary notification: Are the plan's written materials in regard to issues, such as grievances or disenrollment rights, consistent with the requirements in regulation? Is the plan's explanation of the lock-in requirement adequate? Is this issue raised in interviews or group enrollment sessions? Is the lock-in requirement stated clearly on the enrollment application?

If there are no major problems with the contract, the regional office will perform reviews on an annual basis. Organizations who are having trouble meeting the requirements of the contract, or who are the subject of complaints, will be subject to closer review. In addition, all hospital admissions by HMO enrollees are subject to the same review by our peer review organizations that is required for non-HMO beneficiaries.

I understand that the New York State regulations make the application process less cumbersome for the profit organization than it was previously. As new HMO's are licensed, I am sure they will seek Federal qualification. This, of course, will increase the volume of my office's oversight activities. At the present time I have a staff of 2½ physicians devoted to HMO's and, of course, will increase that number as the need arises.

Thank you for the opportunity to make these points.

[The prepared statement of Ms. Wilson follows:]

PREPARED STATEMENT OF JACQUELINE G. WILSON

My name is Jacqueline G. Wilson and I am the Acting Regional Administrator of the Health Care Financing Administration for Region II. Region II encompasses New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands. I am pleased to be here today to discuss the administration of the HMO/CMP program under Medicare.

BACKGROUND

Medicare reimbursement on a prepayment basis to HMOs has been authorized since the program's inception. Initially, however, prepayment authority was restricted to Part B services. Prepayment organizations were permitted to receive 80 percent of their reasonable costs or elect to bill Medicare on a fee-for-service basis. If reimbursement was based on costs, the organization had to prepare cost reports and was subject to audit and cost adjustment. Neither approach was consistent with the operating philosophy of HMOs, that is, to accept in advance a fixed per capita payment, regardless of the medical services actually rendered.

With the Social Security Amendments of 1972, some progress was made in providing a reimbursement mechanism more consistent with HMO operation. Cost-based reimbursement was extended to cover both Part A and Part B services and a modified risk basis option was made available. Under these modified risk contracts, the plan shared equally with Medicare in the savings it achieved up to 20 percent of total payments. However, final settlement of reimbursement was still made retrospectively and this was often not settled until years after services had been rendered. There were no modified risk contracts in the New York Region and few nationwide.

TEFRA RISK CONTRACTS

In 1978, HCFA began to use its demonstration authority to develop prospective payment risk basis contracts. These demonstrations led to the enactment, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), of permanent authority for risk sharing contracts for HMOs and competitive medical plans (CMPs). Payment is at 95 percent of the projected average per capita cost to Medicare for enrollees in the same geographic area under fee for service—that is, what's known as the average adjusted per capita cost (AAPCC). Under these TEFRA risk contracts, if Medicare's payment rate is more than what the plan would charge non-Medicare enrollees for the Medicare benefit package—that is, the plan's adjusted community rate (ACR)—the organization must provide Medicare enrollees with additional benefits, a reduction in premium or some combination of the two which equals that difference.

We believe that the availability of these risk contracts is a historic turning point for the program. It marks a decisive move away from intrusive regulatory schemes for controlling costs to an approach that instead utilizes increased competition and consumer choice. It is through capitation that we will succeed in controlling costs while still providing quality services.

Nationally, we began signing risk HMO contracts on April 1, 1985. As of January 31, we signed 105 risk contracts with organizations in 26 states, covering close to half a million enrollees. An additional 74 contracts that would enable us to enter 10 other states are pending. Currently in New York State, we have 5 risk contracts with 12,689 enrollees and 2 cost contracts covering 1,559 enrollees. There are three risk contract applications pending. In these organizations, even with our tight budget environment, beneficiaries are receiving additional benefits beyond those available to enrollees in fee-for-service at no or limited additional cost and Medicare's payments are less, on average, than in the fee-for-service sector. We believe that this is an indication that everyone—the beneficiaries and the federal government—wins with capitation.

Because we are convinced that capitation is the answer to health care reform, we are proposing to build on the existing TEFRA options through a voluntary voucher system. Under this plan, we would: allow indemnity insurers to qualify for capitation payments; allow employers to combine Medicare with their own plans to secure a uniform plan for their annuitants without duplicative coverage; and eliminate some over-regulatory requirements in current law.

QUALIFYING CONDITIONS FOR RISK CONTRACTS

You have asked for our comments on the entrance of for-profit HMOs into the New York State market. Let me first state that the statute and federal regulations clearly define the organizations that are eligible to enter into risk contracts and the qualifying conditions they have to meet before a contract can be signed.

For HMOs, any organization which meets State law and is federally-qualified under Title XIII of the Public Health Service Act, as Dr. Seubold will describe, is eligible to apply. For Competitive Medical Plans (CMPs), an organization must be determined by the Public Health Service to meet the statutory definition, which includes the requirement that it be organized under state law. For all practical purposes to Medicare, both HMO's and CMP's are the same—entities that provide a full range of health care on a prepaid capitation basis. In addition, both HMOs and CMPs must have at least 5,000 non-Medicare enrollees or 1,500 if it serves a primarily rural area. It must also have at least 75 Medicare enrollees or an acceptable plan to achieve this membership within 2 years.

There are five areas covered in the qualifying conditions for a contract. They include:

Administration and Management—The organization must demonstrate that it has sufficient administrative capability to carry out the requirements of the contract and that it has no agents, management staff or persons with ownership interests

who have been convicted of criminal offenses related to their involvement in Medicare or Medicaid or other Social Security Act programs.

Operating Experience and Enrollment—The organization must demonstrate that is has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate.

Range of Services—The organization must demonstrate that it is capable of delivering to Medicare enrollees the range of required services, i.e., all Part A and Part B services.

Furnishing Services—The organization must furnish the required services to its Medicare enrollees through Medicare certified providers and suppliers. It must also ensure that all services for which the Medicare enrollee has contracted are available and accesible and are furnished in a manner that ensures continuity.

Quality Assurance Program—The organization must have an acceptable quality assurance program.

If an organization meets these requirements, HCFA will sign a contract. There is no basis for denying a contract if the applying organization is for-profit, nor do we think that such a barrier to competition is desirable. Each plan, that meets the qualifying conditions, one of which is financial stability, should be allowed to enter the Medicare market. Beneficiary choice and the rigors of the market should determine which organizations succeed.

Once a contract is signed, HCFA still has a role of ensuring that the organization continues to meet the qualifying conditions of the contract. This oversight function is the responsibility of the regional offices. HCFA is developing a protocol to assure that future monitoring is done in a consistent manner across regions. It covers a wide range of areas from marketing to grievances and appeals. For each area, there will be elements to examine based on concrete factors. For example, in the area of beneficiary notification:

Are the plan's written materials in regard to issues such as grievances or disenrollment rights consistent with the requirements in regulation;

Is the plan's explanation of the lock-in requirement adequate—is this issue raised in interviews or group enrollment sessions—is the lock-in requirement stated clearly on the enrollment application.

If there are no major problems with a contract, the regional office will perform reviews on an annual basis. Organizations who are having trouble meeting the requirements of the contract or who are the subject of complaints would be subject to closer review. In addition, all hospital admissions by HMO enrollees are subject to the same review by our Peer Review Organizations that is required for non-HMO beneficiaries.

CONCLUSION

We believe that our capitation program is working to the benefit of both our beneficiaries and the federal government and we will do everything in our power to ensure its continued success.

When Congress passed TEFRA, Medicare embarked in a new direction, toward a system of cost effective quality care provided in a competitive environment. We are working toward having 25 percent of our beneficiaries enrolled in capitated settings by 1990; and that, we hope, will only be the beginning. By the start of the next century, the health care market place will look very different than it does today. Through the expansion of options, beneficiary choice will have a greater impact on that market, and that is where the locus of decision making rightfully belongs.

I thank you for the opportunity to discuss these issues with you. I'd be happy to respond to any questions that you may have.

Mr. MANTON. Thank you, Ms. Wilson.

Our next panelist will be Dr. Frank Seubold.

STATEMENT OF DR. FRANK SEUBOLD

Dr. SEUBOLD. Thank you very much, Mr. Chairman. Like Ms. Wilson, I would like to submit my formal comments for the record, and at this time just highlight the activities of our office.

The Office of Health Maintenance Organizations has been in existence since the act was passed back in 1973, and has been engaged in both the promotion and regulation of HMO's since that time. The promotional aspects were terminated in 1981, at which

time the purpose of the act in that area was believed fulfilled, and since that time our activities have been mainly regulatory in nature. This means that we evaluate applications from organizations that wish to show that they meet the requirements of the statute and the regulations, and once that determination has been made, to monitor those organizations through a formal reporting process during the periods of their operation. Because of that particular role, when the TEFRA statute was enacted, we were delegated the authority to review applicants for competitive medical plan status in the same way as we had been doing the HMO's. As Ms. Wilson pointed out, there are great similarities between these two kinds of organizations and, as a result, the things that we look at are their ability to correct health services; their administrative organization; their financial arrangements, to assure their fiscal viability; back-up to their marketing plans; and their quality assurance and utilization control measures. All of these are important to assure that those individuals who enroll in the HMO's will get what they paid for and over the years will continue to get what they pay for.

Our process is one that has evolved over the years. We use not only our own staff, but specialist reviewers, individuals who have had distinguished careers in the HMO industry, both to facilitate what we do and to provide greater credibility for the process.

Over the years we have qualified over 400 health maintenance organizations. Our work in the CMP field is just beginning. We take very seriously this challenge to assure that the act is effectively put into operation by these HMO's; we monitor them according to a formal process; when necessary we will take action if they are not living up to their assurances; and in this context we relate very closely to the State regulators to make sure that we are mutually supportive in those actions that we undertake.

The industry has indeed undergone a great change in about the last 5 years. There are many new actors who have come into the field, most principally those well-capitalized, well-managed firms that have the capacity to expand into multistate, if not yet considering national action. Among these, of course, there is a substantial number of "for-profit" organizations. We have yet in our monitoring to find any significant difference between the performance of these "for-profit" organizations and of the "not-for-profits," who were the original protagonists of HMO activities, even before the act was passed.

I am available for any questions you may have.

[The prepared statement of Dr. Seubold follows:]

PREPARED STATEMENT OF FRANK SEUBOLD, PH.D.

Mr. Chairman and members of the Subcommittee, it is a pleasure to appear before you today to discuss the role of the Public Health Service in the program designed to provide Medicare beneficiaries with an opportunity to receive their health benefits from prepaid health care organizations. By enrolling in such organizations, Medicare beneficiaries have the advantages of an organized delivery system providing a comprehensive range of health services and continuity of care. Furthermore, beneficiaries will receive from many prepaid organizations a broader range of services than are covered under the traditional Medicare program. These advantages are expected to be very appealing to beneficiaries, particularly to those who do not have established physician relationships.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amended the Social Security Act to permit eligible organizations to enter into contracts with the Health Care Financing Administration (HCFA) to provide prepaid health care to Medicare beneficiaries. The legislation establishes two categories of eligible organizations: federally qualified health maintenance organizations (HMOs) and competitive medical plans (CMPs). The Office of Health Maintenance Organizations in the Health Resources and Services Administration, Public Health Service, is responsible for determining whether an HMO or CMP is eligible to negotiate a contract with HCFA.

We believe that it is crucial that these organizations provide top quality medical care and be sufficiently fiscally sound to take the financial risk involved, since the success of this new program will in large part depend upon these factors. The Public Health Service has been qualifying HMOs since 1974, and over the years has gained considerable expertise in assessing the performance of prepaid health plans. It has developed successful processes for reviewing applicants for Federal qualification and monitoring approved organizations for continued compliance. We are applying this same expertise and utilizing comparable review and monitoring procedures to assess competitive medical plans, since CMPs are organizations which have many requirements identical or similar to federally qualified HMOs.

I should perhaps add here that HMO activity has been growing at an exceptional rate in recent years. In the year ending June 30, 1985, HMOs gained 3.8 million members, a 25% increase over the prior year. Interest in obtaining Federal qualification also grew: 97 HMOs were qualified in fiscal year 1985, one more than in the three previous fiscal years combined. That pace has not slowed. Two other recent developments in the industry deserve comment. One is the rapid expansion of multistate HMO firms such as Kaiser, CIGNA, PruCare, US Healthcare Systems, Maxicare, HealthAmerica and others. About 65% of all HMO enrollment is in plans owned or managed by just the 12 largest of these firms. Closely related to that development is the increase in the number of for-profit HMOs. The InterStudy census shows an increase in the percentage of HMOs that are for-profit from 18% in 1981 to 36% in 1985. As of the latest count, half of the Federally qualified HMOs are for-profit.

In terms of HMO performance, our monitoring of qualified plans has shown no difference between those that are for-profit and those that are not-for-profit.

I would like to review briefly with you our activities to approve and monitor prepaid organizations serving Medicare beneficiaries. It will probably be useful to begin by mentioning some similarities and differences between HMOs and CMPs.

HMOs and CMPs provide a comprehensive set of health care services including hospitalization, physician services, laboratory, x-ray, and emergency care to enrolled members for a pre-determined, fixed fee. The health care services must be available and accessible to all members and provided in a manner that guarantees continuity of care. These organizations must accept full financial responsibility for the cost of providing medical care and absorb the loss if actual costs exceed the amount collected through premiums. Eligible organizations must be fiscally sound and must assure that health plan members will continue to receive health services for which they have paid even if the health plan becomes insolvent. Finally, HMOs and CMPs must have quality assurance programs and systems for handling member grievances.

There are also several important differences between CMPS and federally qualified HMOs. Generally, CMPs have greater flexibility in how they are organized, in how they develop their benefits package, and in how they establish their premiums. CMPs are not required to provide as many benefits as qualified HMOs, and many charge deductibles and higher copayments for specific services. In addition, CMPS do not have access to employers through the "dual choice" provision, that portion of the Federal HMO law which requires certain employers to offer qualified HMOs.

However, both HMOs and CMPs which receive a Medicare contract under the TEFRA provisions are responsible for the entire Medicare benefit package—either through direct service provision or subcontract with other parties.

Entities desiring to become federally qualified HMOs or eligible CMPs must complete an application. Over the years, we have refined the application for federal qualification to make it more manageable for applicants and for our reviewers. Today, there are 346 federally qualified HMOs serving about 18 million people. In addition, we have developed and distributed to over 400 individuals and organizations a CMP application that fully addresses all eligible requirements. We consider the application an effective evaluation tool, but fully expect it will be modified as we learn more about the variability of different models of CMPs. To date we have received 34 CMP applications and certified 15 eligible.

The HMO qualification and CMP eligibility applications require detailed information and back-up documentation in the following areas:

1. Legal requirements describing the organizational structure and contractual arrangements;
2. Health services delivery system;
3. Financial standing; and,
4. Marketing plans and methods.

In addition, HMOs applying for federal qualification are required to provide specific information about their management.

Once a complete application is submitted, we use staff and consultant specialists to examine closely the information provided for each of these functional areas.

Consultant reviewers are highly qualified experts who manage or work for HMOs, and, together with our own staff, constitute a multidisciplinary team. Each specialist is responsible for reviewing the application to identify potential issues. The team participates in a site visit to validate and clarify information in the application. Following the site visit, a report is prepared which encompasses all relevant aspects of the HMO's or CMP's operations.

As an outcome of the process, an organization meeting all requirements is determined to be either a federally qualified HMO or an eligible CMP. Organizations failing to meet all requirements are denied certification or may receive an intent to deny. The latter is used when it is judged what the barriers to qualification or eligibility can be resolved in a relatively short time period. The Health Care Financing Administration is then notified of our decision on the eligibility of an organization to enter into contract negotiations. Upon successful negotiations, a contract is signed between HCFA and the HMO or CMP, and the organization may begin to enroll Medicare beneficiaries.

We are also responsible for assuring that federally qualified HMOs and CMPs with Medicare contracts continue to comply with the organizational and operational requirements of Federal law and regulation.

Our compliance process has three primary functions: acquiring information about ongoing operations; analyzing the information; and taking corrective action, if needed.

The information that is collected is gathered from routine reports on costs, revenues, membership, and utilization; reports from State regulatory agencies; complaints received about the HMO or CMP; and reports from regional office and OHMO staff visits. Information on each HMO and CMP is analyzed for variances with legal and regulatory requirements, projected organizational goals, negotiated assurances, and industry norms. If warranted by the analysis, a formal process is followed for corrective action. Failure to make the necessary corrections leads to loss of eligibility and notification to HCFA. Any such organization that does not continue to comply with these requirements will no longer be eligible for a Medicare contract and will have its contract terminated. Such action has been taken with one HMO and one CMP thus far in the program.

Finally, the PHS assesses and monitors the quality assurance programs of federally qualified HMOs. With regard to the Medicare contracts, PHS reviews the internal processes of the plans that protect quality. Everyone involved in this program is well aware that assuring high quality health care is of utmost importance. For us, it is an integral part of the review of the health services delivery systems and of the ongoing monitoring. It must remain the central focus of our efforts.

To assure the success of this new program, we are working closely with HCFA to share information and findings and avoid duplicating activities. Offering Medicare beneficiaries the advantages of prepaid health care is a major initiative of the Administration. The cooperative efforts of PHS and HCFA to make this program a reality and a success should ensure that Medicare beneficiaries will be satisfied participants in this new venture.

Mr. MANTON. Thank you, Dr. Seubold.

The next panelist is Mr. Horinka, Director, Bureau of Alternative Delivery Systems, New York State Department of Health.

STATEMENT OF DAVID HORINKA

Mr. HORINKA. Thank you, Mr. Chairman.

I welcome the opportunity to talk to you today and to share with you the State's prospective on HMO's.

The purpose of my testimony today is to describe one of the State's approaches for insuring health care at affordable cost through HMO's.

Governor Cuomo demonstrated his commitment to HMO growth by making a pledge to double the enrollment in New York's HMO's by the end of 1986. At the time of his pledge, New York State's HMO enrollment was 1.1 million residents. As of December 1985, the New York State HMO enrollment was approximately 1.5 million. We expect to meet our goal by the end of 1986 with over 2 million residents enrolled in HMO's. Indeed, by 1990, we expect that over 30 percent of New York's population will be enrolled in health maintenance organizations.

Department of Health began reviewing the regulatory framework for HMO's in 1984, with the objective of encouraging more HMO growth and clarifying in greater detail certain operational requirements for existing HMO's. While article 44 of the Public Health Law which governs HMO's is silent on the issue of "for-profits," the State's policy in the past was to rely entirely on "not-for-profit" HMO's. In order to encourage growth through increased competition, the policy decision was made to permit the entry of publicly traded "for-profit" HMO's in New York State. In order to do this extensive revisions in the regulations were needed to provide the procedures and criteria to certify and monitor publicly traded "for-profits." These revised regulations became effective December 10, 1985. I would like to highlight for you some key areas of the revised regulation.

According to the regulations a New York State presence must be established by every new HMO. We require that out of state corporations incorporate in New York State and that offices be established to house the HMO operation. Separate books and records must be maintained by the New York State HMO operation, and they must be acceptable for State audit. The governing board must have one-third New York State residents, and within 1 year of operation, 20 percent of the board members must be enrollees. In addition, we require that the governing board have autonomy from any parent organization in the decisionmaking process. Character and competence reviews must be done on the governing board members, officers, directors and controlling persons, that is, those who own 10 percent or more stock in the corporation. This review extends to the health care operations of these individuals outside of New York State, and also includes the review of the performance of other health care operations of the holding company.

The monitoring and surveillance role of the Department of Health and the State of Insurance Department is defined in the regulation. It is the statutory responsibility of the Department of Health to review each HMO no less than every 3 years. Regulations also specify the right of the Commissioner or Superintendent of Insurance to examine the HMO and all participating entities at any time. Holding companies are also subject to examination if there is reasonable cause. Any transaction of 10 percent or more of the HMO's admitted assets at year end must receive the Commissioner's prior approval. Any changes in control of the HMO, sales or loans, are also subject to prior approval by the Commissioner.

The role of management contractors is defined in the regulation. The governing board of the HMO must retain responsibility for policy making and overall operation, and cannot be delegated to a management contractor. Management services may be provided through an approved management contract only, and the terms must be clear and payment must be reasonable and feasible.

Financing arrangements, solvency, and enrollee protection are also reviewed. Capitalization is reviewed by the Department of Health and the State Insurance Department. All contracts with health care providers require prior approval of the Department of Health before execution. Contracts with providers must have a "hold harmless clause" to protect enrollees from liability for covering services.

Quality assurance is addressed in the regulation. The framework to address quality assurance within the HMO must be established with an internal audit system which includes peer review. In addition, the administration on the governing board must review the operation of the quality assurance program. Since the State Department of Health conducts periodic audits, the HMO must have access to medical records and internal out-of-State access as well.

Grievance procedures to handle enrollee complaints are mandated. There must be an effective grievance procedure with an appeal process to the governing board. Regular reporting of grievances to the State Department of Health is required.

HMO's as managers of care select the providers that will be under contract to provide services. However, the HMO may not discriminate by class for any class of providers. The employer requirements in the regulations state simply that all employers with 25 or more employees residing in the HMO service area must offer all HMO's. Employers are not obliged to pay more for the HMO option than they do for other health coverage.

The HMO applicant must indicate its willingness to provide community services. This willingness must be expressed in writing and include a timetable for implementation. The regulations define community services as offering the HMO option to the following groups: Medicaid beneficiaries to local departments of social service contracts; Medicare through supplemental package or a HCFA risk contract; an open enrollment for employers of small groups of five or more. Progress on the community services provision is monitored and reviewed, and when the HMO seeks expansion, that the Department of Health have periodic statutory review.

With the substantial benefits available to HMO's, the State in turn expects that New York HMO's will deliver high quality care in a cost-effective manner and will not deny the HMO options to any individual based on age, health status or payer source. This means the HMO option should be available to employed individuals, small groups, Medicaid and Medicare. Should HMO's not meet these expectations of the State, the benefits now available to them may not be continued in the future.

The immediate effect of the policy to permit publicly traded HMO's in New York was indeed increased activity among existing "not-for-profit" HMO's in New York. The increase in activity, competition and growth in the "not-for-profit" sector has been dramatic during the last 6 months. We currently have seven service area

expansions under review and additional mergers are being contemplated.

Insurance carriers are creating separate lines of business for the HMO option in order to maintain their market share. since HMO's are not subject to franchising, we have no formal method to limit the entry of HMO's in any given geographic area, nor do we have the guidelines for a penetrational level which will constitute saturation of an area. What we do know is that we are far from any projected saturation point with only 8.8 percent of the population statewide enrolled in HMO's. The State's commitment to the growth of HMO's is not a blanket endorsement.

Many New Yorkers view with skepticism the introduction of entrepreneurs in the form of publicly traded "for-profit" corporations into New York's health care industry. The Department of Health views their entry with cautious optimism. We intend to monitor the performance of new publicly traded "for-profit" HMO's very carefully. We also intend to hold the existing "not-for-profit" HMO's to a continuing high standard of performance. The pressure on employers and government to control rising health care costs will continue to increase. So the need to encourage the development of effective health care alternatives will also increase. Effectiveness means more than keeping costs down; it means delivering a high-quality product at an affordable price.

The goal of HMO's is a very ambitious one. That goal is to deliver comprehensive services of a consistently high quality, while controlling the cost of that care. However, it is a goal that we can all endorse and for that matter test by close scrutiny. The State intends to monitor the performance of HMO's very closely. We are working very hard to develop a statewide quality assurance program that permits some flexibility among HMO's. It insures that the quality of care of high and that enrollee health outcomes are positive. We will monitor underutilization as well as overutilization. We review new applicants to assure that excessability, availability and quality of providers are included in the HMO health care delivery system.

The State and Federal Government, employers and the provider community will all be watching the performance of HMO's. While the recent Harris poll and numerous studies have documented the performance of HMO's, the debate over the cost and quality is more lively than ever. Since August 1985 numerous articles have appeared in the Wall Street Journal, the Times, and other publications, citing the concerns of many employees that HMO's do not guarantee savings and health benefit costs. Reasons cited include the effective community rating on their premiums, a tendancy for younger; healthier individuals to enroll, leaving the higher-risk employees with traditional insurance plans. You can all count on this debate to continue. An increased surveillance by employers will be a decisive force in the future direction and growth of HMO's. The most recent polls still show that more employers are satisfied with HMO's than are dissatisfied.

Whether it be through HMO's or some other mechanism, managed health care is here to stay. In my opinion, physician management of a patient's care results in better care for that individual. Capitation is the method of reimbursement that rewards a physi-

cian for effective patient management. A practice not encouraged or rewarded by the cost based fee-for-service reimbursement methodologies of the past and presence. Capitation also encourages the use of out-of-hospital, lower cost health care services that are appropriate based on an individual's medical needs. The Department of Health remains committed to the availability and accessibility of quality care. I feel that increased utilization of HMO's offers a cost effective health deliver system that will benefit both society and the individual.

Thank you.

Mr. MANTON. Thank you, Mr. Horinka.

Permit me to direct a question to you: You mentioned geographical areas of saturation, and in earlier testimony we heard about the need to avoid adverse selection of participants in order to make an HMO successful. Do you think that there might be some deliberate targeting of the geographical area which may be more affluent or higher income or less poor, in order to avoid the so-called adverse selection and end up oversaturating certain areas of HMO's, and how can we deal with them?

Mr. HORINKA. I am certain that there could be the potential for that type of activity to go on, but I would think that, particularly in New York where we have a commitment on the part of the State to insure that HMO's offer their unique managed care concept to all individuals, that any HMO that targeted a specific, small geographic area and appeared to be limiting their marketing efforts to a younger, less higher risk population would be, if I may, nudged quite a bit by the State to increase and expand their service area.

I also think with the competitive forces that would prevail with so many HMO's, that it would be necessary for each of them to expand and will be forced to move into many different geographic areas that perhaps 7 or 8 years ago we wouldn't have seen that happen.

Mr. MANTON. That's why I said there were really no mechanisms in place to detect this type of operation.

Mr. HORINKA. Well, the mechanism that I believe is there is that community service commitment. Upon review of an application we will find——

Mr. MANTON. But if you don't have enough Medicaid or enough Medicare enrollees, that will be an early warning, so to speak?

Mr. HORINKA. That would be a signal that the HMO may not be prepared to expand into what may not be to them an advantageous area.

Mr. MANTON. Thank you.

I will direct this question to either Ms. Wilson or Dr. Seubold.

Your comments focused on monitoring HMO's as it relates to Medicare participants. To what extent are your efforts concentrating on Medicaid eligible participants?

Dr. SEUBOLD. In terms of the quality of care that is provided, the emphasis is precisely the same, and that goes across the board for all enrollees within an HMO. We get information from observing the characteristics of the plan, in terms of the reutilization of services, which can flag a situation in which, perhaps, we were seeing below utilization. We can get direct complaints from individuals

who are enrolled or we can get information from the State regulators who are frequently closer to the scene than we are. But in any case, the quality of care is equally a concern across the board, and the manner in which the HMO follows through on its internal quality assurance system, which must be approved before it can be qualified, is watched carefully.

Mr. MANTON. Thank you.

I will direct this last question—because we are again trying to stay on target—to Ms. Wilson: If I were an elderly Medicare participant in an HMO when it was federally certified, and I had a complaint, what would happen at your level once I filed that complaint?

Ms. WILSON. Well, first of all, the complaint would be made to the HMO if it's about services. One of the contract is that they do have some grievance procedures in place. If the complaint was made directly to the Health Care Financing Administration, we would take a close look at the organization again. We would go and do an onsite review to see whether or not there is anything to that particular complaint.

Mr. MANTON. Thank you. I thank the entire panel No. 2. We will have other questions, and we will submit them in writing for your response. Thank you, very, very much.

Dr. SEUBOLD. Thank you.

Mr. HORINKA. Thank you.

Mr. MANTON. The last panel, panel 3, consisting of the providers, will be made up of Dr. William J. Kane, M.D., president, U.S. Health Care, Inc.; Mr. Henry J. Werronen, senior vice president, Group Health Division, Humana, Inc.; and Mr. Warren D. Paley, president, Capital Area Health Plan, Inc.

Before the panel starts their testimony, I would just like to announce that I have to leave. I have an appointment at the Lexington School for the Deaf to tour the facilities that was made and it is long standing. The record has already indicated that our staff director, Mr. Blancato, will remain and conduct the rest of the hearing.

So, thank you very, very much for your indulgence. I would turn the hearing over to Mr. Blancato for the balance of the testimony.

Mr. BLANCATO. Thank you, Mr. Chairman.

Why don't we take a minute's recess while the Congressman safely exits.

[Recess.]

PANEL THREE, CONSISTING OF WILLIAM J. KANE, M.D., PRESIDENT, U.S. HEALTH CARE, INC.; WARREN D. PALEY, PRESIDENT, CAPITAL AREA HEALTH PLAN, INC.

Mr. BLANCATO. Dr. Kane, please proceed.

Dr. KANE. Thank you very much.

STATEMENT OF WILLIAM J. KANE, M.D.

Dr. KANE. My name is Dr. Terry Kane, I am the president of U.S. Health Care, both in New York and in New Jersey. I am a physician. I am trained in New York State. My previous experience includes private practice in New York State, a faculty position at

Duke University Medical Center, and hospital administration for a number of years.

I represent U.S. Health Care Systems. We are the first certified, investor-owned HMO in the Metropolitan New York area. We are also the leading multistate operator of HMO's with programs in Pennsylvania, New York, Florida, New Jersey, and Illinois. And soon, in 1986, we will expand into Texas, Washington, DC, Maryland, and Virginia. We currently serve more than 1 million members and our HMO is an affiliated organization. We appreciate the opportunity to speak with you today.

Your staff has asked me to address the following: Our company's position on the New York State regulations; a prediction of the effects of those regulations on HMO's in New York; a comparison and contrast of New York with other HMO markets in which we operate; a visual demonstration of our approach to the marketplace; and a discussion of internal monitoring mechanisms which we utilize.

New HMO regulations have been promulgated by New York State to further the objectives of doubling the enrollment in HMO's in the State. This allows both "not-for-profits" and the "for-profits" to expand. The department of health along with the insurance department in New York State held several meetings, conducted extensive dialog with interested parties before the regulations were finalized. We believe that the departments' efforts have resulted in regulations which are practical and useful.

For the financial aspects of the regulations, they require that we, in order to do business in New York, be incorporated in New York State, make management decisions here, exhibit financial responsibility, and submit all contracts for State regulatory approval. On their face we have no problems with these regulations. I would make three comments about the regulations and the review process: The emphasis on quality assurance is extremely strong, and appropriately so. We accept the obligation to deliver a quality health care client, utilizing private physicians and the private provider network. We believe that managed health care and competition in New York will definitely decrease costs while increasing quality and accountability.

Second, the regulations apparently governing hospital reimbursement, we believe, are somewhat restrictive. We would hope that the health department will remain flexible and permit us to develop new and innovative ways of paying for medical care, such as capitation and utilization of prospective payment. "Fee-for-service" and per diems are an incentive to overutilize and provide little or no incentive to control costs or increase efficiency. The interface between competition and regulation in New York State will need constant monitoring to insure the best aspects of both. The potential exists to be overly restrictive, thereby limiting the ability of HMO's to reform the current delivery system.

Third, the review process itself was thorough, fair and conducted by dedicated State employees. It took almost 7 months for U.S. Health Care to complete the process of licensure. We believe the dialog between New York State and U.S. Health Care was constructive for both parties, and we certainly welcome the opportunity to prove ourselves in the pre-operational phase.

To summarize then, we endorse both the clinical and the business-oriented aspects of the New York State regulations. We believe that they will have a positive effect on health care in this State, provided they are administered by State regulators capable and willing to allow innovation and change.

I was also asked to compare the New York marketplace with those areas in the country where we also operate. U.S. Health Care operates in some of the bigger metropolitan areas of the country, including Chicago and Philadelphia. New York is clearly bigger, a great deal bigger, and from the health prospective, especially in a competitive environment, New York is not very sophisticated or knowledgeable about what competition will bring.

Health care costs and utilization in New York are excessive. The city itself is characterized by marked overcapacity of tertiary care. I should emphasize that I am speaking about the Metropolitan New York area, because that is the one we are familiar with.

Physician fees in the metropolitan area are also excessive as compared to fees elsewhere in the country. There is also a marked physician oversupply, especially in the more technical subspecialties.

I should comment that the malpractice environment state for physicians is also detrimental to health care cost containment, and we would urge some attention to this problem.

The public in New York has, up to now, been provided very few alternatives to costly fee-for-service medicine. We have high expectations for enrollment growth when New Yorkers realize that they can have comprehensive care and preventive services, physical exams, no deductibles, no claim forms, and 24-hour coverage when needed. They will also be able to choose from hundreds of private physicians' offices. Further, HMO members will be given assistance with weight loss, stopping smoking, stress, and we will even reimburse for physician activities, and YMCA and YWCA memberships. We believe that this will be healthy for the other insurers in New York and that they will be forced to generate similar benefit packages to remain competitive. The result of this has to be good for the people of New York.

Regulations require participation in Medicaid and Medicare. We will participate in the Medicaid program and are actively exploring mechanisms for this in New York City. We have already applied for a Medicare risk contract in New York. This will be our third program. We already operate risk programs in Philadelphia and Chicago and currently have more than 16,000 enrollees in those areas. We charge no premium for our Medicare plan and provide complete health care for the Medicare recipient. Our ability to manage this program will again be assisted by the ability to modify the currently wasteful health care system. We do have some concerns about the 95-percent reimbursement level. We find this level is inconsistent from one geographic area to another within the United States. We examine each one individually. This 95-percent level has to be maintained and monitored in the future.

I spoke a few minutes ago about the effects of a good program on health. We would like to show and were requested to show you some videotape of commercials produced for the New York marketplace, as well as some that were produced for other areas and will

be modified for New York State. If I can ask Sara or Allen to put the videotape in, we can see just a few minutes of commercials.

Mr. BLANCATO. For those who cannot see it, I would suggest you move over.

Dr. Kane, beside the commercials is there anything else?

Dr. KANE. No.

Mr. BLANCATO. Why don't you continue on, and if suddenly you are stopped, you will know we got it working.

Dr. KANE. Let me just continue on while they play with the wonders of science.

I would like to close with just discussing some of the mechanisms of quality assurance in our system and the methods in which we monitor the quality of care.

I should start by saying that there is much discussion about quality assurance in HMO's. I wish there was as much discussion about quality assurance in the fee-for-service system. I think all HMO's monitor quality assurance far more aggressively than, perhaps, the fee-for-service system.

Our quality assurance mechanisms include the following: First, is physician screening. Not all private physicians are able to participate in our IPA's. There is a thorough process involving a face-to-face interview with every physician, a visit to the office, and an examination of medical records.

Second, we operate a very extensive management information system which tracks every patient encounter; compares performance of physicians with peers; looks at referral patterns, drug utilization, and many other components of the health care delivery system. We operate a full-time member relations department with toll-free numbers around the country and have formal grievance procedures. We recertify every office and every physician that participates with us on an annual basis, based on the management information system, and our encounters with the physician. Each year we randomly certify large numbers of our members to ascertain their satisfaction with the health care delivery system. Twice a year we conduct medical care evaluation studies with specific standards, looking at each office in our system. And, finally, we maintain a full provider-relations professional staff that visits offices on a regular basis and relates to them on a 1-to-1 personal basis.

The quality assurance mechanisms of U.S. health care are extensive and I think that those following us into New York State will find out that New York State will require such process to be served by.

In closing, we very much look forward to our New York operation. We believe that New York has made the right choice in allowing investor-owned HMO's to enter the market under a comprehensive and strict set of regulations. Competition will bring efficiency, innovation, and quality care at lower cost to New York.

Thank you.

[The prepared statement of Dr. Kane follows:]

PREPARED STATEMENT OF DR. WILLIAM J. KANE

HEALTH MAINTENANCE ORGANIZATIONS: THE NEW YORK EXPERIENCE

Feb. 24, 1986, New York—Congressman Biaggi, I would like to thank you and your committee and its staff for the opportunity to present my testimony today. We at U.S. Healthcare are excited about operating the first investor-owned health maintenance organization in the metropolitan New York City area, and we are mindful of our responsibility not only to provide a quality health care delivery system, but also to participate in forums such as this. We want the public to be informed about what we are doing. We know it is important to develop public recognition of our program and our efforts to fulfill our social responsibilities.

The staff has asked me to address the following: our company's position on the new New York State HMO regulations; a prediction of the effects of those regulations on the state of HMO's in New York; a comparison/contrast of New York with other HMO markets; a visual demonstration of our approach to the marketplace; and the various internal system monitoring mechanisms which we employ.

A lot has been said about the new HMO regulations which have been promulgated by the New York Department of Health to further its objectives of doubling the enrollment of HMOs in the state and promoting the expansion of for-profit and not-for-profit HMOs. The Department of Health, along with the Insurance Department, held several meetings and conducted an extensive dialogue with interested parties before the regulations were finalized. We believe that the department's efforts have resulted in regulations which are practical and useful. They do require HMOs to influence health care, even manage it. We think that is a positive development. Managed care is the shape of things to come in New York. Although the physicians participating in our program are not our employees, but are independent private practitioners, we find, nonetheless, that the clout of the marketplace gives us the ability to require certain health care related standards for participation in the HMO program. Given sufficient HMO membership, the medical community is anxious to provide services to our members with standards of care that we can influence to the benefit of the member/patient. To give you an idea, we have more than 500,000 members in the Southeastern Pennsylvania/Southern New Jersey marketplace and more than 7,000 physicians who have agreed to our contract terms for providing services for these people. We are not timid about the ability of a market driven health care delivery system being influenced by the payor. Thus, we are not concerned by the patient protection requirements of the new regulations. We can influence the delivery of health care.

If you are interested in a current report card for the state's regulators upon whom we are depending, I will give you one. Of course, we have not even reached mid-semester break in our freshman year; however, we have found the Department of Health (and the Insurance Department) to be extremely cooperative and thorough thus far. It took approximately seven months of work from the filing of our application until our New York license was granted. During this period, we were reviewed, re-reviewed, previewed, questioned, interrogated, and, we felt, folded, mutilated, bent and spindled. In other words, they were very thorough, more than in any other state. But we applaud that. We understand that along with the tremendous opportunity to serve New York State comes tremendous responsibility, and we welcomed the opportunity to prove ourselves and provide a pre-operational comfort level. Now we welcome the opportunity to market and provide services.

I have been asked to compare New York with other marketplaces. New York is bigger. New York is also less developed as a health care marketplace. New York is in for some big changes in the next few years. I can hardly wait to see what happens when New Yorkers wake up and learn what Chicagoans, Philadelphians and others know: that they can have comprehensive health care, including preventive care and even routine physical exams, at low cost, with no deductibles, no claim forms, and 24 hour coverage when needed. And they will have a choice from amongst hundreds of private physicians' offices, not clinics. Further, our HMO members will be given assistance with weight loss. We will help them stop smoking. We will pay to help them cope with stress. As for the business aspects of the new regulations, they require that in order to be in the HMO business in New York you have to be incorporated here, make management decisions here, exhibit financial responsibility and submit the contracts through which you provide services, the rates you pay and the rates you charge for state regulatory approval. On their face, we have no problem with these regulations. We do, however, have some concern. We hope that state regulators will permit us to develop new and innovative ways of paying for medical care, ways that will be reflected in lower premiums for members

and their employers and help keep the cost of health care down. We have found, for instance, that once we have a large enough membership, some physician and hospital groups will be willing to accept responsibility for member care in return for reasonable fixed monthly payments. Thus we have developed what we call a complete capitation program in which physicians and/or hospitals assume some of the financial risk for providing health care to HMO members. This departure from the traditional fee-for-service system is one of the approaches that can help control health care costs. It is also, in our opinion, one of the changes that has been slow coming to New York because there has been little incentive to innovate. We believe that is about to change.

To summarize, we endorse both the care and business oriented aspects of the new New York HMO regulations. We believe they will have a positive effect on health care in the state, provided they are administered by state regulators capable and willing to allow innovation and change.

We even reimburse them if they work-out at a Y or other fitness center. Once word gets out that these benefits are available from U.S. Healthcare, the marketplace will force other HMOs and the traditional insurers to follow suit. The result has to be good for the people of New York State.

Incidentally, some HMOs have been accused of skimming, because they offer their services primarily to employer groups which, some say, are a healthy population. Please understand that we have applied for federal qualification in New York, and that means that by law no one will be turned down because of a pre-existing health condition. We will accept people regardless of their state of health. Also, the new regulations require that we express a willingness to provide Medicare and Medicaid services and conduct enrollment of small groups. We have already applied to the federal government for a Medicare contract and are anxious to start what would be our third Medicare program. We are already offering our HMO Medicare recipients in the Greater Chicago and Philadelphia areas, where we provide complete health care for no premium. The federal government merely continues to deduct the approximately $15.50 for the Medicare enrollee's monthly Part A and Part B payment and pays us 95% of the government's average cost of care in the area. We find that the government's payment is sufficient. There is that much fat in the traditional system. Despite what you have read in the paper during the past week or so, there is no need for new legislation to protect Medicare recipients or others against catastrophic loss. Given a fair payment and some program management, the HMOs can do it. Of course, that is only possible if we are given the freedom to modify the traditional and wasteful fee-for-service system in which the medical care community was told that the more they treat and the more they spend, the more they earn.

In addition to applying for a Medicare contract, we have began discussions and hope to obtain a Medicaid contract or contracts in New York and are exploring means to offer our services to small groups.

I spoke a few minutes ago about the effects of a good program on the health care delivery system once the marketplace gets word of that program. I would like to show you some videotape of commercials produced for the New York marketplace and some produced for other areas that will soon be modified to run here. (Film.)

I would like to add a few comments about our quality assurance program. When you see commercials claiming that we take care to select physicians to serve U.S. Healthcare members I want you to appreciate why we can say what we do. I believe that the first quality control measure occurs during the screening of providers for the program. We visit every physician who applies. We look at the office to see that it is clean and professional. We review charts. We check appointment books to make sure that the physician operates by appointment, sees no more than four or five patients per hour, and generally keeps people waiting no longer than about 15 to 20 minutes. We also have a full time member relations staff to answer questions about the program and help members use it, a grievance procedure and quality assurance and executive committees composed of participating physicians who police themselves. We recertify each physician annually. We conduct patient satisfaction surveys. We are also very sophisticated users of data processing, with management information systems that enable us to continuously review referral patterns, drug utilization and other aspects of patient care. Clearly, although we do not provide care in the sense that doctors do, good HMO companies such as U.S. Healthcare are changing the health care delivery system by managing care. This is something that the traditional indemnity insurance companies have never done, and it is creating issues that they are now being forced to face or they will lose business. We feel that the introduction of investor-owned HMOs into New York State will create the business pressure that did not before exist. This will lead to managed care. It will lead to better care and help control costs. We feel that the presence of U.S. Healthcare

in New York State will mean good business not only for U.S. Healthcare and other HMOs that manage care, but also for the people of New York.

Mr. BLANCATO. We will continue our efforts to allow the completion of your testimony in individual form. In the meantime, Mr. Paley, why don't we allow you to proceed with your statement.

STATEMENT OF WARREN D. PALEY

Mr. PALEY. I am Warren Paley, and I am the president of the Capital Area Health Plan, Inc., and also the New York State Regional Conference, which represents all of the operational HMO's in New York State.

For those of you who are still watching the video, the telephone number is 1-800-457-9853. And that might help put you at ease, if that message got across.

The interest that I have in coming before you is to try and summarize some answers to questions that were asked. I have submitted testimony and I will not read that, but rather just organize my remarks around answering some of the questions that I was asked to direct myself to.

First of all, I want to say that the whole theme of accountability is fair enough and I am really appreciative that the committee is interested in that. I would like to point out, however, that there might be a slightly wrong interest in the views from the Congressman as far as a paragraph that says that "obviously the new regulations provide a set of major incentives for profit organizations coming into this State." Maybe it is a misunderstanding, but I don't think that the regulations merely provide a group of major incentives. They merely permit "for profit" HMO's to enter into HMO activities in the State of New York, and I think that's good, but I think the inference should be corrected, at least.

I would also like to say, in deference to some of the former speakers, they had some tremendous points. And when you heard about the regulations from Mr. Horinka and also from Dr. Seubold, that the HMO's in this room, this arena, this New York State, are regulated either by a combination or one of the Federal regulations and the State regulations, and whether it is both or one, I can guarantee you that they probably the best regulated HMO's in any state in our nation. So that some of the concerns, at least in New York State, should be less than in other states that I am familiar with.

The new regulations, OK. I was asked to comment on the position of the new article 44 regulations. I will summarize this as quickly as possible.

First of all, the accountability is there. You listened to the testimony of Mr. Horinka. The regulations must be meted and played fairly to succeed and we have every hope that they will be. If in fact everybody has to meet the same conditions, I do not see any problem with the regulations as far as insuring the accountability of the HMO's and their populations. I would like to point out that the regulations do not speak specifically to a Medicare population, but actually to a population, an overall across-the-board population in every case. The regulations do ask that Medicare and Medicaid

be included in the cross section of a population that an HMO enrolls, and I think that is fair enough.

Of course, in representing the New York City conference there are mixed feelings on what some aspects of the regulations provide. I should state that in the interest in doing business as quickly as possible and as efficiently as possible, and taking advantage of some of the possible savings, HMO's in New York State have been concerned with the fact that all provider contracts and transfer of funds, for example, must be renewed at the state level. If in fact this happens, I hope that it is done in a way that meets the very quick pace of activities in any one of the HMO's in New York State.

As far as the Medicare population is concerned, I think that the regulations in themselves will provide a very positive P.R. for HMO's in New York State, because it sort of makes it right for employers, for consumers, for institutions, they get a good feeling about HMO's in New York State because the regulations are so specific as to so many various aspects of the program, including boards and, also, the managers, the physicians, and the quality assurance programs. So, the regulations do provide, I believe, the accountability that the committee is looking for.

The effect of these regulations I was asked to comment on in New York State HMO's, and the possible need for greater oversight. I have already sort of touched on that. My first answer is I believe that the HMO's in New York State really do not need any new additional set of regulations than have already been put in force. I think that the Medicare beneficiary, no matter what model the HMO engages in its activities—for example, the Capital Area Community health plan that I represent is as staffed as some group model overlaps, but other models, I think the regulations talk fairly across the board to the various models of HMO activities.

I would like to assure that the Insurance Department and its function in carrying out these regulations carefully review the premiums that are set by the various HMO's to prevent the possibility of gaining market share unfairly, which would possibly lead to skimming, et cetera. That has been mentioned by many of the other witnesses. I think this is a very important aspect of the regulatory function.

I would also like to echo Mr. Biblo's concern about keeping in force the notion of community rating because, in fact, it will a no system of insurance if we continue to erode the system of community ratings. It will be a cost-plus thing, and that will lead to all kinds of unfairness in the marketplace and really promote the idea of skimming, et cetera. So that is a caution on that.

The examples of self-monitoring mechanisms within your HMO which police quality of care as well as fraud and abuse, Dr. Kane stated pretty much what goes on in a lot of the HMO's in New York State. Our HMO in particular has had in force a quality assurance program from day one, and all the HMO programs that I am familiar with do have, and the new regulations talk very specifically to having quality assurance programs in place. Not only are the operations of the quality assurance program, which really is a self-auditing system, in place, but then there are boards of direc-

tors who are responsible for their care and it is very clear that these boards of directors are approved at the State level.

The board itself then is another self-monitoring effect for quality assurance. Although that hasn't been mentioned, I think this is true of most of the HMO's if they are in accordance with the regulations.

Most of the HMO's I am familiar with also have, without regulation, a mechanism to meet and hear the concerns of any of their consumers. We, in fact, had a subscriber concerns mechanism where, in fact, the complaints can go all the way up, or the problems can reach to the level of the board, and the board again has its subscriber component so that the feeling of the consumer is there throughout the process.

Again, I would like to echo Dr. Kane's remark about the fact that HMO's are light-years ahead of fee-for-service in monitoring quality of care. And this is a little different than Mr. Perry's testimony. He said earlier that he didn't see that there was any particular difference between the fee-for-service world in monitoring care than the HMO world. I think this is untrue. I think there is a real, real difference, and a much better sense of reviewing all of the applications that start with a provider sector of the HMO to make sure that they are the quality of physicians that one would have as their own, and so on.

The experience—I was asked to comment on the experience of the not-for-profit HMO's by the HMO's that now have risk contracts. I would just like to point out that there are HMO's in New York State that are involved with a Medicare population for some time prior to the advent of the risk contract. So there has been some experience with HMO Medicare beneficiaries well in advance of the risk contract. The experience thus far has been chiefly, on the risk contract, with an HMO in Rochester, NY. They have a little over 6,000 subscribers, Medicare subscribers, enrolled under their risk contract. Apparently they have had a great deal of success with acceptance by the Medicare subscribers and have a very low disenrollment rate. That is one way that HMO's measure their success with the consumer. As a matter of fact, for some reason, and it might be due to competition by other HMO's for the other population, their disenrollment rate is very, very much lower, significantly lower than the rest of their population.

Medicare beneficiaries in HMO's are very happy with the fact that a lot of decisionmaking process has been taken on by the HMO for their care. That is a tremendous benefit. The second thing that is a tremendous benefit is the fact that they don't have to really mess around with a very complicated, less understood system of claims management. In other words, the Medicare beneficiary in the fee-for-service world really has to be a manager and this is a very difficult process, particularly as we get older, to understand all the ins and outs of that.

I would like to just go back a hair on some of the reimbursement things and some of the problems with the act as it exists now. The two-for-one rule has been a real problem in New York State, and I believe there have been complaints lodged with the New York State Insurance Department. The two-for-one rule is simply saying that if an HMO, as it exists currently, has an enrollment of Medi-

care subscribers under a cost contract, that they need to gain two members for—I mean, they have to have two members under the cost contract for every new one that they enroll. Usually the people that enroll under the risk contract in fact have the pleasure of somewhat better premium because, in fact, some of the gains that might be made would be returned to the HMO. Therefore, the HMO's in the competitive sense have lowered the premiums by how it works out for them on experience. In our case, this is true and the people who have been the longtime friends of the HMO and enrolled under a cost contract wonder why they are being abused, but that is Federal law and that probably ought to be changed.

The other thing is that since New York State has had a very important mechanism in place for years in controlling cost, at least in the hospital sector, the DRG system, which now is looming, may in fact provide a real problem for New York State HMO's, at least in upstate hospitals. The DRG's may, in fact, go out ahead of the current pricing for a Medicare stay, in which case, those HMO's who are receiving their revenue base on the past experience under the AARPC will in fact have a disadvantage from the standpoint of the income. Their income will be lower because it will based on past experience and it will take some time for the higher payment to the hospitals under the DRG system to be reflected in the HMO cost accounting of the AARPC.

Another problem that was mentioned also by somebody, I think it was Mr. Biblo in answer to your question, the DRG system may in fact become a real disincentive to the HMO's, of really controlling and managing care, if in fact they are not entitled to a different payment scheme than under the DRG's. In many cases our patients—we have a very fine home care program—our patients are out of the hospital, even with Medicare patients, much before the regular fee-for-service world patient would be because we had a wraparound way of caring for patients outside of the hospital as well as in the hospital. The preadmission testing that we now do, there would certainly be a disincentive for that continuing if, in fact, the DRG demanded from us, as well as other payers, the same reimbursement for a length of stay, let's say, for any one of a thousand different examples. So that is a concern.

I would like to just briefly touch on an example of our marketing techniques. I'm not sure that I trust the TV screens. Let me tell you about them. First of all, oddly enough, at least in our neck of the woods, the TV has not been the best instrument to get our message across. And apparently the way of reaching our public the best and most efficiently is through written material that is mailed to the home or delivered to the home. Second, I would like to say that there are certain newspapers or journals that are more or less directed, or parts of these papers that are directed at a Medicare population, and their inserts have been valuable. But TV has not been the most beneficial way of reaching our Medicare population. We do have examples of forms of advertising, reaching the Medicare population, I would like to say to this committee that our goal has always been fair play. We have found from our long experience and other HMO activities that the best policy is to put it straight. We are not the answer to all people, we make that clear, and we do

not falsify in any way what we say. This only comes back to haunt, watching other HMO's, their operational experience. So the advertising thing, although it may be slick in some cases, I think in the end that will probably self-regulate itself.

I hope in the zeal of all the HMO's participating in the New York State arena, that they do not get into those kind of acts that will confuse particularly the Medicare population, because I think that is very anticommunity minded, and I think the New York State HMO Conference will play a very strong hand in keeping at least those kinds of things straight.

I could go on, but I will stop right now.

[The prepared statement of Mr. Paley follows:]

TESTIMONY OF THE NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE

My name is Warren Paley and I appear before you today as President of the New York State Health Maintenance Organization Conference. The Conference consists of all 18 HMOs presently operating in New York State, which serve approximately 1.4 million enrollees. Members of the Conference range in size from HIP of Greater New York to Elderplan with approximately 1,000 enrollees, and Whittaker Health Services which recently became certified in New York. All federally qualified or state certified HMOs operating in New York State belong to the Conference.

In my personal capacity, I serve as President of Capital Area Community Health Plan, the second largest HMO in New York State, which has been operational for nine years and which serves approximately 85,000 members in eastern and northern New York as well as western Massachusetts and Vermont. CHP is federally qualified and is based in Latham, New York.

The HMO Conference welcomes the opportunity to present its views to you on the important issues of how Medicare dollars are spent on HMOs in New York State, and how quality care is assured. Although your letter requesting testimony focused on issues related to risk based reimbursement contracts with Medicare, I would like to point out that many HMOs in New York State have a long history of serving Medicare beneficiaries under cost based contracts with Medicare. Our interest in the new risk contracts is therefore not a new interest in Medicare beneficiaries themselves, since we have in fact been serving these beneficiaries for many years.

It is my understanding that 6 HMOs in New York State have obtained the new risk contracts with the Health Care Financing Administration. The first to obtain such a contract was Genesee Valley Group Health Association (a group model HMO in Rochester) which was followed by Preferred Care (an IPA model in Rochester) and Capital Area Community Health Plan in Albany (a staff model). Health Insurance Plan of Greater New York (a group model) is on the verge of obtaining a risk contract as a competitive medical plan (CMP) while Blue Choice in Rochester (an IPA model) and Rochester Health Network (an IPA/network model) have recently obtained CMP status. [Those HMOs which are state certified under Article 44 of the New York State Public Health Law, but which are not federally qualified, apply as a "CMP" rather than as an "HMO".] It is likely that other HMOs in the State will apply for the risk contracts in the future.

1. The position of the New York State HMO Conference on the Health Department's new regulations is somewhat mixed. On the one hand, the Conference opposed certain individual components of the regulations, such as prior approval of contracts with new providers and transfer of certain funds within the corporation. Our opposition was based on the fact that certain provisions are extremely "regulatory" in that many day-to-day business decisions of the HMO require the approval of the Health Department staff. This is not to say that the HMOs do not accept the indisputable notion that general regulatory oversight is necessary for HMOs, just as it is necessary for other providers of hospital and medical services. However, the HMO Conference feels that in many instances the regulations cross the line from general regulatory oversight and became unduly management oriented. This concern was fueled by the fact that the Health Department staff, although certainly well-intentioned, is not likely to be able to process paperwork and grant approvals with the dispatch necessary to conduct a large enterprise's daily business operations.

On the other hand, other portions of the regulations may turn out to serve a useful public information service by providing a more formal assurance to the public that the internal workings of an HMO are in fact organized and optimally structured. Many aspects of the new regulations codify in regulatory form what was already existing practice for New York State HMOs. The fact that employers, trade groups and the public in general see these provisions as legally binding guidelines enforced by a state agency may cause them to feel more comfortable than they would knowing that these same practices are "merely" an HMO's internal policies.

For example, several people have approached me and asked how I feel about the new regulations requiring our HMO to have a quality assurance program! I was stunned to learn that these people were not aware that HMOs already have such programs. Our HMO, and every other HMO I know of in New York State, has an extensive quality assurance and utilization review program which has been in place since our HMO obtained federal qualification in 1977. The quality assurance program involves staff from all divisions of the HMO and includes review of problem cases as well as randomly selected cases.

The quality assurance provisions in the new regulations were taken, in large part, from the Health Insurance Plan of Greater New York's quality assurance program. Since HIP has such a long history as an HMO, and nearly 900,000 HMO enrollees, they have a more elaborate quality assurance program than some of the smaller and newer HMOs. However, at the request of the HMO Conference, the quality assurance regulations were made flexible enough to accommodate the different quality assurance programs of a 5,000 or 10,000 member HMO than a 1 million member HMO. However, in either case the bottom line is that all HMOs in New York State have quality assurance and utilization review programs because they are necessary to function as an HMO, and these programs predate the Article 44 regulations which were adopted in December of 1985.

The regulations govern the operation of the HMO as a whole and do not distinguish the applicability of the regulations based on who pays for the coverage, such as the enrollee, an employer, Medicare or Medicaid. For example, there is only one quality assurance program for the HMO, which applies to all enrollees. The only provision of the regulations which specifically relates to Medicare is the community service [§98.5 (b)(18)] provision which, among other things, requires that the HMO offer coverage for persons eligible for Medicare, whether as Medicare Supplemental insurance coverage (a cost based contract with HCFA) or a risk contract. The purpose of this provision is to assure that persons in the HMO who reach age 65 are not left without coverage because the HMO does not offer a product tailored to the needs of persons eligible for Medicare. Almost all HMOs already offer a product for persons eligible for Medicare and the Conference wholeheartedly supports this concept. This provision is another example of the regulations codifying existing practice. The nature of the reimbursement payments from HCFA is a matter left to the HMO's discretion (no one is forced into a risk contract) but the important issue is that no one eligible for Medicare should be unable to continue their HMO enrollment.

2. It is difficult to predict the effect the new regulations will have on HMO development in New York State for not-for-profit HMOs or for for-profit HMOs. The popularity of HMOs is due far more to the comparative merits of other health insurance plans available in the community (be they from an employer or Medicare or Medicaid) than from state government efforts to promote HMO development.

The new regulations are extremely comprehensive, especially concerning quality assurance and financial aspects, and there is no apparent reason to add further new regulation at either the federal or state level. It would appear that New York's extensive regulation of health care providers, such as hospitals, will now be extended in similar form to HMOs and therefore New York State will be in the forefront of states regulating health care activity. While there are no doubt some attendant claims of over-regulatory practices which the HMO Conference will question in individual instances, on the whole it is difficult to imagine a more extensive regulatory network for the protection of the public which could be both workable and yet still add significant marginal regulatory benefits beyond the regulations which are now in place.

3. Our own quality assurance program at CHP is typical of the structure used by other HMOs. We have a Quality Assurance Committee comprised of the Medical Director and representatives of each department (surgery, obstetrics, etc.) and representatives from each of the regional health centers we operate. The Committee meets monthly and one of its key functions is to oversee and coordinate the quality assurance programs which are operated by the individual departments. The individual departments must demonstrate to the QA Committee that the department is au-

diting its own performance and that they are in fact taking corrective action when the audit reveals the need for such action.

It should be noted that quality assurance is not a purely retrospective activity. A truly effective quality assurance program begins when physicians are hired or selected to contract with the HMO. Thoughtful review of the academic and professional qualifications of physicians during the recruitment process is the first step in any quality assurance program.

Issues are raised in the quality assurance process by three different methods: (1) review of the results of medical record audits by the individual departments within the HMO (i.e., surgery department, obstetrical department, etc.); (2) issues raised by Health Services Representatives, who are the employees designated to handle grievances and assure that subscribers' interests are adequately represented; and (3) individual staff members who submit proposals as to how we might better handle a particular type of case.

I certainly cannot sit before you and claim that the medical care provided by HMOs is perfect; there are of course occasional problems. However, I can assure you that the HMOs in New York State are doing their best to maintain, and constantly improve, their quality assurance programs. Frankly, I think HMOs are light years ahead of the fee-for-service sector in monitoring the quality of care and assuring that appropriate remedial actions are taken. While HMOs are not perfect, they certainly are far more extensively involved in quality assurance programs which focus on the physician as provider than the fee-for-service sector which Medicare spends far more on.

4. There is not any significant amount of experience with the risk contracts in New York State. Genesee Valley Group Health Association began its risk contract operations in 1983 as a demonstration program and now has 6,600 enrollees. Mr. Raymond Savage is the President of GVGHA and he is away this week so I will summarize his comments for you. Their experience to date has been very favorable because the elderly population with its greater health care needs seems to be more appreciative of the coordination of care function that an HMO provides. The over 65 enrollees also seem to greatly appreciate the lack of claim forms and paperwork in the HMO. To date only 3% of those who have enrolled in the GVGHA risk contract have terminated their membership, which is significantly less than the 16% rate which is the average rate at GVGHA. The quality assurance program for the GVGHA Senior Care program is integrated with the overall quality assurance program, and includes both random medical audits and follow-up investigation in problem cases. The Plan has an Assistant Medical Director whose sole function is to oversee the quality assurance program, although he does have occasional clinical duties. The other HMOs' risk contracts are too new to have any useful experience.

One problem which has already arisen is public dissatisfaction with the "two for one" rule which requires that two new enrollees be recruited for every one enrollee who converts current HMO coverage into risk contract coverage. Our Plan has received a number of complaints, and I have been informed by officials at the New York State Insurance Department that they have received numerous complaints, from irate current enrollees who are upset because they cannot transfer their current coverage with us to the risk contract benefits and premium level. The risk contract premium is in fact less than what these enrollees pay to us now and we are in the difficult position of telling our current (often long-term) members that they cannot join, yet these people see us advertising and recruiting other enrollees who have never before belonged to our HMO.

The New York State HMO Conference is also concerned that the current pricing mechanism for the Medicare risk contract payments to HMOs both (1) unfairly discriminate against New York State and (2) have long-term financial incentives which pose the likelihood of creating the very atmosphere which you, in holding this hearing, are trying to examine and avoid.

New York's long history of cost control in health care has limited health care costs in relation to those costs in other states. The HCFA payment to HMOs of 95% of the AARPC therefore results in an unusually low ceiling for making payments to HMOs in New York State, while HMOs in other states are paid at 95% of what are often largely unregulated health care costs. An even more direct problem may result from the transition to DRG hospital payments. The HCFA payment to HMOs is based on historical hospital costs, yet the projections from New York State hospitals are that they will receive more money in hospital reimbursement from DRG payments for Medicare patients than they did under the per diem payment system under NYPHRM. The result will be that HCFA payments to HMOs will reflect historically lower hospital reimbursement payments than will in fact be made under the DRG methodology and will therefore be inadequate.

It is also important to note that the HCFA payment methodology will result in a gradual reduction in the fee-for-service cost ceiling from which the 95% AARPC is calculated. HMOs will begin to work against their own past experience as future reimbursement levels are calculated upon the HMO's own cost effective performance in prior years. Changes from 95% of AARPC to any lesser portion of AARPC will have an even more dramatic effect.

Once an HMO has enrolled a substantial Medicare risk population these gradual, or perhaps dramatic, reductions in HCFA payments to HMOs will bring tremendous pressure to bear on HMOs to continue to provide the same scope of benefits at increasingly lower reimbursement levels from HCFA, and will thereby perhaps encourage the very behavior which you are concerned about and which prompted you to call for today's hearing.

I would also ask that you resist efforts to weaken the Federal HMO Act. That law has done more than you can imagine to assist HMOs in gaining the foothold they were so long denied. The federal Act's requirements for operational structure and quality assurance programs have set an example for all the states to follow and millions of health care consumers are the beneficiaries of that wise legislation.

5. In terms of marketing techniques, the GVGHA Senior Care program does not use extensive television advertising. Instead they have found that direct mail programs which insert brochures into premium notices are the most effective, while advertising in small regionally oriented weekly newspapers is the second most effective method.

At CHP we have experimented with television advertising and have found it to be too expensive for the numbers of persons involved. We expect to rely heavily on print advertising.

Examples of advertising from both Genesee Valley Group Health Association and Capital Area Community Health Plan are being submitted with this testimony.

In conclusion, I would like to say that the New York State HMO Conference welcomes the opportunity to present its views to this Committee, and extends an offer to work with you in the future. It is our firm belief that well-run HMOs offer the potential of quality care at a lesser cost to millions of Medicare recipients who all too frequently have health care needs which are disproportionate to their ability to pay for those benefits.

I am sure your examination of the HMO experience to date in New York will provide you with solid assurance that care can be provided in an HMO setting that is of high quality, and which is humane and appealing, but which is also cost effective. It is far too soon to predict whether or not the regulations on the whole, or that portion of the regulations which expressly permits for-profit HMOs, will have an impact on HMO development in New York State or on the quality of care delivered by HMOs. It is the position of the New York State HMO Conference that the final test is not organizational structure but rather whether an HMO provides quality care and whether the public is well served for the premium it has paid. We feel we can meet both those challenges and therefore provide an extremely valuable public service.

Mr. BLANCATO. Thank you very much, Mr. Paley.

I assume Mr. Werronen was unable to make, which means you should have a clear shot at the market, right?

Our intention in holding this hearing, before all the calamities today took place, was to open up the discussion basically in some people's eyes. We had a few questions asked of our subcommittee as to "Why are you having a hearing on HMO's at this point?" And in reality, we want to use this as sort of an opening process to both educate people as to the existence of HMO's, but also as a means of indicating our interest and wanting to monitor activities of HMO's.

The testimonies that have been received have been outstanding and we appreciate them, and they help build the kind of hearing record that we will need to further educate ourselves as to the HMO experience in New York. We anticipate further hearings. We anticipate further subcommittee activity with respect to HMO's, and we also welcome anyone who came here who, as a result of what they heard, which is to make a contribution to the subcom-

mittee hearing record by submitting a statement to our Washington office. We will be happy to accept them. We normally keep our hearing records open for 2 to 3 weeks after the completion of hearing, both for new testimony, but also to allow those who did testify to make any changes they feel necessary to help make their case more clear.

At this point, I am stunned to believe that we finished 10 minutes early, considering the nature of our undertaking. Are there any comments from anybody in the audience? If there are not, then what we will do is recess the hearing subject to the call of the new Chair, whoever it may be the next time we do this.

Thank you all for coming.

[Whereupon, the hearing was adjourned at 12:50 p.m.]

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